PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	A Qualitative Evaluation of a Mandatory Health Insurance 'Wait Period' in a Publicly Funded Health System: Understanding Health Inequities for Newcomer Im/migrant Women
AUTHORS	Hamel-Smith Grassby, Maggie; Wiedmeyer, Mei-ling; Lavergne, M.; Goldenberg, Shira M.

VERSION 1 – REVIEW

REVIEWER	Young, Charlotte Australian Catholic University, Allied Health
REVIEW RETURNED	24-Jan-2021

GENERAL COMMENTS	This paper presents empirical findings from a study exploring the impact of wait-times on migrant women's healthcare experiences, particularly concerning sexual and reproductive health care. The findings draw attention to a flawed policy that results in significant health inequities for migrant women. These findings are essential for promoting targeted reduction of health inequities for migrants through policy change. It was a pleasure to review this paper which makes an important contribution to current knowledge concerning migrant experiences of health and settlement, however, I also think the paper would benefit from some revisions. Most significant, is reference to intersectionality in this paper, which in its current form, is inadequately described and engaged with. My comments are below: At the top of page 5, the sentence that ends with 'economic challenges in destination settings' requires some support with a citation. The methods section would benefit from greater clarity and detail: The authors mention 'focus participants' on page 5, line 41, and it is unclear what this means. Should it be 'focus group participants'? In the section regarding patient and public involvement, the authors mention that community partners and participants shaped the analysis's focus and participated in 'member checking'. Some more detail concerning exactly how their feedback influenced the analysis would help the reader gauge the level of 'community engagement'. How many participants contributed through member-checking? Furthermore, the principles of community engagement adhered to are not referenced in this section (line 36, page 5).

	Additionally, it would be useful to know how the advisory group was recruited. Who makes up this group? What exactly was their role and influence over the study? The participants characteristics could also benefit from greater detail for the reader to understand to whom findings apply and determine the generalizability of the study. Table 1 & 2 may benefit from providing more specific information, for example, instead of using the category 'other' to capture a large number of participants, I recommend that the authors identify all the 'regions of origin' and 'primary languages' among their sample. Specifying the country of origin is a useful characteristic to disclose given the great diversity among geographical regions. The analysis section also requires more detail: On the top of page 7, it is not clear exactly how the codes and themes were determined; could the authors provide some of the references used to inform how they approached their content analysis? Could they also provide examples of the process, such as how the initial codes became categories, became themes? On page 7, line 17, the authors refer to 'intersectional theory' which should instead be ‘intersectionality', as it was described by Crenshaw. While the authors refer to intersectionality, it is unclear to what degree this theory informed this analysis. Could the authors provide more detail and clarity around their understanding of this theory and how it informed the findings? The application of this framework needs to be explicit supported by appropriate references. It might be useful to delineate more clearly between those participants who are immigrant women and those who are staff from community-based partner organisations when reporting quotations. On page 9, line 16, the authors mention that participants described 'devastating consequences of children being subjected to the wait policy'. There are strong examples of this in the quotations presented to support this statement, however, they are placed under a different theme - 'D) Negative Health Implications'. Perhaps the statement and the data in Table 4 could be better aligned. The final theme presented in the findings section, 'Community support and connection: mitigating isolation and supporting access to care' could benefit from more participant quotations that support the authors statements in this section. Table 5 has only two quotations that do not speak to everything the authors state in this section. The authors state that intersectionality informs the findings. However, more substantial representation of this is needed in the discussion and findings sections. In its current form, the analysis does not adequately connect with this theory. More robust explanation of the participants' positionalities and the systemic drivers of oppression and privilege is required throughout the paper to highlight rigor in the analysis and the connection to intersectionality. In the strengths and limitations section, the authors highlight the intersectional approach as a strength of the study but imply that it

	is the sample of women that makes this an intersectional study ('but limited research has taken an intersectional approach with a uniquely gendered sample.'). There is limited engagement with this theory in the paper in its current form and the explanatory power of intersectionality is not adequately utilised. The authors may wish to refer to Collins and Bilge (2016) and more of Crenshaw's work to engage this theory with their findings fully and develop the analysis further along these lines. The authors fairly point to their positionalities as presenting possible limitations to this study. Further detail and reflection on this point would be useful. For example, how exactly does the authors' positionality affect the data collection, analysis, interpretations, etc.? Line 3, page 14, states 'including those not well-represented in previous quantitative studies (eg, those with precarious or insecure status) and Canadian research'. This statement requires referenced examples of relevant studies that reinforce this point. Line 50, page 4, states 'The intersections of im/migration status, racism and sexism are particularly concerning, given research showing these factors can shape healthcare needs both independently and together, with newcomers, racialized individuals and women often facing more immediate or severe health and socio-economic challenges in destination settings.' This statement requires referenced examples of relevant studies that reinforce this point. Finally, there are some inconsistencies with spelling/grammar throughout, for example, the authors use 'eg.,' and also 'e.g.'

REVIEWER	Caulford, Paul The Canadian Centre for Refugee and Immigrant Health
REVIEW RETURNED	03-Feb-2021

GENERAL COMMENTS	An informative and important contribution on a relevant and under researched topic on access equity. It adds to the specifics of the access barriers. It expands details within the barriers. This information is essential to addressing policy and developing and implementing solutions. In these regards the paper is worthy of publication. The selection process for participants may offer study limitations and bias? This should be addressed in limitations. The authors state the women interviewed experienced multiple reasons for their status delays. How certain is it that reasons other than the 3 month provincial delay are not influencing their responses? And their perceptions of harm and their description of the degrading experiences and impacts of public health access to care delays? The authors rightly reference jurisdictions in Canada that removed/reduced accessibility and eligibility barriers to public health system care during COVID 19 for Im/migrants. The 4 references cited in the introduction however predate COVID 19. In Ontario (referenced by the authors) it was in March/April 2020 that the provincial government began providing universal full access to all services for all uninsured newcomers in Ontario regardless of status, who receive care in a hospital setting -- ER, in patient,

	outpatient. This reviewer has attached 2 files for the authors review and reference. The non-hospital OHIP codes for care in community provider settings, while helpful for access, are incomplete and do not cover laboratory, DI services. or specialist fees. This has resulted (in our organization) on a greater reliance on the ER for primary care urgent problems not needing the ER. We also experienced wide variability among hospitals, some applying the new rules without barrier, others reluctant to and even turning our uninsured away. This added to confusion and feelings of shame and shunning felt by the Im/migrants. The methods section overall provides the study protocols and data collection. The project description section provides needed context and detail that addresses my questions regarding the methodology section. In the Discussion the authors state "It is unacceptable that 10 years later our study has identified these same ongoing concerns." This is an opinion (one this reviewer shares). Reframing this opinion in the context of a social responsibility and ethics question is suggested. (e.g. Ethical issues in Women's Healthcare: Practice and Policy. Lori D'Agincourt-Canning and Carolyn Ells; Oxford University Press)

REVIEWER	Caxaj, Susana Western University
REVIEW RETURNED	18-Feb-2021

GENERAL COMMENTS	Overall, this is a very important contribution to the field, especially because of the inclusion of precarious status migrants and the focus on women's experiences. The findings are very accessible yet compelling, the level of partnerships that were leveraged towards this project are impressive, and the writing is easy to follow and focussed. I do have however several concerns, many of which I believe must be addressed before this paper is published. They are detailed below ARTICLE SUMMARY (1) Article summary - final bullet point is difficult to follow and I find the claim too broad (all research may not be generalizable to any subgroups). There are also 2 statements here and I don't find that they fit well together. I suggest focussing on either (a) a particular subgroup that was not as well represented in your sample that may limit generalizability to that target group or; (b) the research process, and your particular strategy. for reflexivity - in what ways was it potentially limited? Another limitation I see is depending on community-based organizations to recruit participants. While from a partnered perspective that ensures adequate referrals this is great, from a representation perspective, the researchers could discuss the fact that there may be another group of people who are not linked to

	organizations or services at all who they were unable to reach in this research. INTRODUCTION (2) Page 4 - I find the framing of paragraph 2 interrupts the flow, as it makes it seem like the article will shift focus to the US before returning to the Canadian setting. Can you finesse this paragraph to fix the interruption in flow? METHODS (3) Under the intro section of MEthods, I suggest either (1) dropping the phrase about the declaration of helsinki OR (2) elaborating on the particular principles that further characterize the ethical protocols of this research from a standard ethical plan (some principles are pretty standard and now considered a low bar, while others may be more aligned with an explicit commitment to health equity) (4) Between the first and second line of "patient and public involvement . . ." subheading there is a tense disagreeement (1st sentence in pressent, 2nd sentence in past). First sentence needs reference at minimum, and ideally, elaboration of what principles these are (5) Since bottom of page 5 states that this project is part of larger project. Larger project should be discussed in methods, and then the specific objectives and research Qs of this project should be outlined in relation tothe larger objectives of the whole project (5) Bottom of page 6 - a description of organizations serving this group would be helpful to understand their reach and track-record with the community of interest/ (6) Last line, page 6 - who translated? was the research team member bilingual in languages spoken by participants? Did the person doing the 'check' possess the same language skills? I think this raises more questions the way it is written than it answers. Perhaps better to just say, All interviews were transcribed and translated. (7) In the findings it's made clear that there were language-specific focus groups. It would be helpful for that to be detailed in the methods (8) Top of page 7 - References for the analytic method used need to be provided (9) Here we are introduced again to the 3-month waiting period focus (that to me is only really stated before in the introduction). If this area of focus was developed through the inductive analysis, this needs to be made clear, and it needs to be contextualized in relation to the research question that was first sought (explicitly early in the methods). If it was the main area of focus from the beginning this also needs to be made clear in the methods. (10) Last lines before results - I appreciate the transparency of explaining how the team found a fit with intersectionality, but I wonder if for the presentation of the findings, whether it makes more sense to use this analysis to provide a more overarching framing of the findings. I believe this will be easier to follow and be more compelling for readers (11) Page 9 - is "fundamentally unjust" the authors or the participants? If the participants I would suggest reframing to make this clear, such "their best to navigate a system they perceived as unjust." I think it is more powerful to make clear that this was the

	perspective, as written, it may appear to be editorializing (as much as I agree) (12) Top of page 10 presents a contradiction. Authors state ". . . unintended pregnancy . . . common." And then state that ONE participant experienced. This needs to be rephrased, can this be SOME? Or, is it that participants agreed this was a challenge, and one participant detailed her experience going through this? (13) Top of page 11, 2nd paragraph, last sentence needs to be tweaked. The impact of what is being stated is lost because it is hard to follow (14) Top of page 12, suggest introducing the quote while being explicit of the tension, that is, while community support helped ameliorate some of the isolation, barriers remained very real for participants, especially during this wait period DISCUSSION (15) Please reframe first section, these are not really implications, rather commentary on the findings as they relate to public health. Otherwise, you could merge recommendations with this section, and provide more action-oriented discussion in these sections STRENGTHS AND LIMITATIONS (16) First sentence - I would suggest removing or softening this claim. The research findings found a good fit with intersectionality and some mention of it is made, this is not the same as taking an intersectional approach. Also, you did not 'gender' the sample, but rather focussed on the experiences of diverse women. (17) You have not addressed racism or explicitly sexism in your findings or discussion. If this was the intention, I would go back and weave into these sections, or nuance this claim somehow. I also wonder if this belongs in the discussion section so you can elaborate on this further. (18) it would be helpful to know where "elsewhere" (internationally? other parts of canada?) (19) Without more elaboration on how this research project was reflexive, and how member-checking contributed to a higher level of reflexivity, I don't think there is enough to substantiate how this qualitative project differed from any other that doesn't purport to have a strong level of engagement and community-based analysis. Can you please elaborate. Consider for example, that member checking is a technique that is used across qualitative paradigms, and can be justified for many reasons (e.g. simply for accuracy or triangulation, including "checking if participants are lying") RECOMMENDATIONS (19) Please elaborate on health for all for those who may be unfamiliar and elaborate on how waiving the wait period would be a component of this. I also would suggest being more sparing with quotes here to not lose the impact of what you are saying. (20) Drop "US" if this is an issue internationally there is no need, and it makes more sense to focus on other countries that have a more similar healthcare system anyway Other small wording issues (1) please remove "entirely" when discussing Ontario waiving period. I find this confusing because it suggests that Ontario has committed to removing the wait period for good, rather than during the current pandemic

VERSION 1 – AUTHOR RESPONSE

Reviewer 1 (C.Y.)

1. Introduction: Line 50, page 4, states ‘The intersections of im/migration status, racism and sexism are particularly concerning, given research showing these factors can shape healthcare needs both independently and together, with newcomers, racialized individuals and women often facing more immediate or severe health and socio-economic challenges in destination settings.’ This statement requires referenced examples of relevant studies that reinforce this point.
Introduction: At the top of page 5, the sentence that ends with 'economic challenges in destination settings' requires some support with a citation.
We appreciate the opportunity to strengthen the relevance of this work and the connections to other findings. We have added references where indicated.

2. Methods: The authors mention 'focus participants' on page 5, line 41, and it is unclear what this means. Should it be 'focus group participants'?
We appreciate this comment and have revised the language to improve clarity. We have adjusted this language to read “interested participants” as this included focus group participants, community consultation participants and providers working in the field. We hope these changes, along with others will allow the study design and methods to be much clearer.

3. Methods: In the section regarding patient and public involvement, the authors mention that community partners and participants shaped the analysis's focus and participated in 'member checking'. Some more detail concerning exactly how their feedback influenced the analysis would help the reader gauge the level of 'community engagement'. How many participants contributed through member checking? Furthermore, the principles of community engagement adhered to are not referenced in this section (line 36, page 5). Additionally, it would be useful to know how the advisory group was recruited. Who makes up this group? What exactly was their role and influence over the study?
We are happy to provide additional clarity regarding the methods section and our patient and public involvement approaches. This has been clarified as follows: “The focus for this analysis, evaluating the impacts of the three month wait-period, arose from these consultations as well as advocacy work conducted by community partners, made urgent by the COVID-19 crisis. Community partners provided feedback that shaped the emphasis and focus of data analysis. For participants who requested a second interview, in-depth follow up interviews inviting feedback on common themes and findings were conducted. Common themes and findings were also shared with participants in other ways (e.g., via videos during COVID-19) and participants were invited to share feedback. These two processes allowed for member-checking, where participants could comment on and reflect on the overall findings as well as their experience during the initial interviews. Participants reported feeling comfortable and included throughout this process and supported recommendations to waive the three-month wait period, hoping for policy change in the future.” (p. 4-5)
Additionally, we clarified the discussion of the advisory group. We now focus on elements of community engagement specific to this analysis, drawing only on information from the larger parent study where this directly informed this work (Methods, p. 4). Community engagement principles used in this specific analysis are now referenced appropriately (p.4, line 15), and the language around those consulted has been adjusted for clarity, including who these individuals were and their specific role (p.5, lines 1-6; p. 6, lines 7-12).

4. Methods: The analysis section also requires more detail: On the top of page 7, it is not clear exactly

how the codes and themes were determined; could the authors provide some of the references used to inform how they approached their content analysis? Could they also provide examples of the process, such as how the initial codes became categories, became themes?
Thank you for this opportunity to explain further. We are happy to clarify that our coding process used an inductive approach, and the selection of themes was determined through discussion and clarification with team members with lived experience of im/migration. The specific codes utilized are now highlighted more clearly (p. 6, para. 2.) We apologize that this was previously unclear. Much of this detail was simplified due to space constraints, but we have edited elsewhere to include more information. We reference the inductive theory applied and explain community led methods that determined the focus of this paper in more detail (i.e., the community activism that sparked the need for this analysis p.6).

5. Methods: On page 7, line 17, the authors refer to 'intersectional theory' which should instead be 'intersectionality', as it was described by Crenshaw. While the authors refer to intersectionality, it is unclear to what degree this theory informed this analysis. Could the authors provide more detail and clarity around their understanding of this theory and how it informed the findings? The application of this framework needs to be explicit supported by appropriate references.
We genuinely appreciate the detailed work and critique that went into this reviewer's (and others') comments on the way intersectionality was used (and potentially mis-used) in this submission. We tried to avoid "flattening" intersectionality (Alexander-Floyd, 2012) by ensuring the focus was on systemic barriers and issues, but we realize that our application of intersectionality theory required further nuance, depth, and detail, and feel that our manuscript has been greatly strengthened in response to the constructive feedback of the reviewers. For example, we have expanded our descriptions of reflexivity within the analysis and explain more clearly how intersectionality specifically informs this analysis and the findings. We highlight areas within the results section where intersectionality informs the findings and their interpretation, with appropriate referencing.

6. Results: The participants characteristics could also benefit from greater detail for the reader to understand to whom findings apply and determine the generalizability of the study. Table 1 & 2 may benefit from providing more specific information, for example, instead of using the category 'other' to capture a large number of participants, I recommend that the authors identify all the 'regions of origin' and 'primary languages' among their sample. Specifying the country of origin is a useful characteristic to disclose given the great diversity among geographical regions.
We agree that diversity between and within countries and regions of origin is very important to highlight. We have edited the participant characteristics table to ensure that all countries that are represented in the sample are included. We very much agree that understanding details of countries of origin, language, and other migration histories are important for contextualizing our data and have done so to the extent possible while ensuring sufficient protection of participants' anonymity. For example, we are unable to add additional detail regarding specific numbers of individuals from each country, since this would increase identifying information and potentially compromise anonymity for some of our participants. Importantly, as our aim in this analysis is not to generalize to other populations, but to provide contextualized understanding of the impacts of the 3-month wait, we expect findings may transfer to other settings where similar structural barriers to insurance access exist, even where characteristics such as language or country of origin may differ.

7. Results: It might be useful to delineate more clearly between those participants who are immigrant women and those who are staff from community-based partner organisations when reporting quotations.
Thank you for this comment. We now clarify this in the methods on page 7 where we write: "Staff

from community-based organizations added important information for context and background information that informed the analysis and narrative findings."

8. Results: On page 9, line 16, the authors mention that participants described 'devastating consequences of children being subjected to the wait policy'. There are strong examples of this in the quotations presented to support this statement, however, they are placed under a different theme - 'D) Negative Health Implications'. Perhaps the statement and the data in Table 4 could be better aligned.
We appreciate the opportunity to provide additional clarity regarding this issue, especially due to the overlapping experiences and contexts (i.e., high costs result in negative health complications for most participants). The context around this quote has been adjusted to ensure it is clear how it fits into this theme of high costs. This now reads:
"In many cases, participants described devastating consequences of children being subjected to the wait-period policy resulting in high costs for parents. Infants born in Canada are eligible to apply for coverage as Canadian citizens, however, in B.C. they are still subject to the three-month wait if their parents are without coverage - a lengthy and important gap for a newborn. Application is typically linked to a parent, and if parents' status is insecure, enrollment application is shaped by fear of detention or removal following reporting to border services. Once (if) enrolled, the infant must still undergo the three-month wait."
Based on this feedback and that from others, we have also slightly reworked the way we discuss certain results, including themes system navigation and high costs. Instead of focusing on system navigation and health costs separately, we have combined them into the larger category of "Administrative Burden" (p. 8). This removes the overlap between two very connected topics and allows for a more nuanced discussion of these interconnected themes.

9. Results: The final theme presented in the findings section, 'Community support and connection: mitigating isolation and supporting access to care' could benefit from more participant quotations that support the authors statements in this section. Table 5 has only two quotations that do not speak to everything the authors state in this section.
Thank you for highlighting an area where added detail would help illustrate the findings. We have included two additional examples of participant experiences that reflect the findings in more detail (e.g., discussion of "door-knocking" and looking for resources, the social support aspects of building community and navigating difficult barriers) in Table 5. An additional quote has been added to the end of the narrative findings section final theme on page 11, which provides an important illustration of how impactful finally receiving health coverage after a long wait was for some participants.

10. Results: The authors state that intersectionality informs the findings. However, more substantial representation of this is needed in the discussion and findings sections. In its current form, the analysis does not adequately connect with this theory. More robust explanation of the participants' positionalities and the systemic drivers of oppression and privilege is required throughout the explanation of the participants' positionalities and the systemic drivers of oppression and privilege is required throughout the paper to highlight rigor in the analysis and the connection to intersectionality.

Discussion: In the strengths and limitations section, the authors highlight the intersectional approach as a strength of the study but imply that it is the sample of women that makes this an intersectional study ('but limited research has taken an intersectional approach with a uniquely gendered sample.'). There is limited engagement with this theory in the paper in its current form and the explanatory power of intersectionality is not adequately utilised. The authors may wish to refer to Collins and Bilge

(2016) and more of Crenshaw's work to engage this theory with their findings fully and develop the analysis further along these lines. The authors fairly point to their positionalities as presenting possible limitations to this study. Further detail and reflection on this point would be useful. For example, how exactly does the authors' positionality affect the data collection, analysis, interpretations, etc.?

Thank you for pointing this out. As discussed in our response above (#5), we completely agree that further work was needed to better incorporate theoretical considerations related to intersectionality within the findings and discussion of our manuscript, and we feel that these changes have significantly strengthened the manuscript. For example, we have expanded description of participants characteristics and explanation of how systemic drivers of oppression and privilege, including racism and xenophobia, shape the introduction, and both the results and discussion, including pages 7, 8, and 9.

“Im/migrants who face converging effects of gendered power dynamics and the responsibility for children’s health, exclusion as a result of racism, precarious immigration status or discordant language experience outcomes distinct from those with privileges associated with male gender, White racialization, secure immigration, and English language communication, which are rooted in patriarchal, racist, xenophobic and colonial power structures.” (p. 7, para. 2)

“Women reported facing racism when being asked targeted questions about their immigration status when trying to access healthcare. This was seen through loud and invasive questioning by medical receptionists who doubted their right to access care and portrayed suspicion when deciding who can “access health care and who can die” (Latin American woman, 7.92 years in BC). Experiences like this, where race is created by structural hierarchies between residents and “non” residents enforced by the wait-period’s exclusion, further attaches race to citizenship.” (p. 8, para. 1)

“Women’s narratives indicated the wait-period imposed a period of extreme vulnerability to high outof-pocket costs and unmet health needs. During the wait-period, lack of coverage for urgent pregnancy and children’s health needs resulted in serious economic stressors and impacts (Table 4). The feminization and racialization of poverty that is both managed and enforced through policies like this that disproportionately impact racialized women cannot be ignored.” (p. 9, para. 1)
The comments specific to the discussion were also raised by other reviewers and highlighted areas of this writing where the explanation of reflexivity required additional attention. We have specified the structural factors at work to produce these findings and hope that this issue has been addressed throughout, making the use of intersectionality theory and reflexive work clearer overall.

“Temporary protection measures offered during COVID-19 are scaling back – as is the case in British Columbia, where temporary health coverage has already been withdrawn. Intersectionality illustrates how a longstanding colonial history rife with xenophobia and racism operate through the three month-wait policy to produce differential health experiences for racialized, im/migrant women. The current policy within this system of structural racism, pits BC residents against incoming (racialized) residents, through the lens of resource scarcity, sustaining exclusion, and making it clear that in Canada, health coverage is far from universal.” (p. 13, para. 2)

11. Discussion: Line 3, page 14, states ‘including those not well-represented in previous quantitative studies (eg, those with precarious or insecure status) and Canadian research’. This statement requires referenced examples of relevant studies that reinforce this point.
Thank you for noting this, all appropriate references have now been included.

12. Formatting: Finally, there are some inconsistencies with spelling/grammar throughout, for example, the authors use 'eg.,' and also 'e.g.'
We have reviewed the paper and references for potential typos and have edited accordingly. We apologize and appreciate the reviewer's helpful attention here.

Reviewer 2 (P.C.)

1. The authors rightly reference jurisdictions in Canada that removed/reduced accessibility and eligibility barriers to public health system care during COVID 19 for Im/migrants. The 4 references cited in the introduction however predate COVID 19. In Ontario (referenced by the authors) it was in March/April 2020 that the provincial government began providing universal full access to all services for all uninsured newcomers in Ontario regardless of status, who receive care in a hospital setting -- ER, in patient, outpatient. This reviewer has attached 2 files for the authors review and reference. The nonhospital
OHIP codes for care in community provider settings, while helpful for access, are incomplete and do not cover laboratory, DI services. or specialist fees. This has resulted (in our organization) on a greater reliance on the ER for primary care urgent problems not needing the ER. We also experienced wide variability among hospitals, some applying the new rules without barrier, others reluctant to and even turning our uninsured away. This added to confusion and feelings of shame and shunning felt by the Im/migrants.

Not only has this comment improved our overall understanding of the Ontario context, but your comments have helped shift the importance of this paper, given that the repeal in Ontario may not be as long lasting as it seems. The files and knowledge you have provided highlights how quickly decisions to repeal this wait-period were made and represent the lack of uniformity, increasing barriers for system navigation. Thank you for your important on-the-ground contributions to this work. The references here have been appropriately time and topic updated, and information of the variability of service has been included to help illustrate this explanation. This now reads: "Canadian provinces determine health coverage independently, leading to a patchwork of waiting periods and 8 coverage policies within the country. During the COVID-19 outbreak, the province of Ontario repealed their wait-period policy, with access remaining variable and limited." (p. 4, para. 1).

2. The methods section overall provides the study protocols and data collection. The project description section provides needed context and detail that addresses my questions regarding the methodology section: "The selection process for participants may offer study limitations and bias? This should be addressed in limitations. The authors state the women interviewed experienced multiple reasons for their status delays. How certain is it that reasons other than the 3 month provincial delay are not influencing their responses? And their perceptions of harm and their description of the degrading experiences and impacts of public health access to care delays?"

Thank you for this important comment. While participants mention the three month wait-period, many also experienced other gaps in health coverage and status delays, the reasons for which were often not clear, yet no less harmful as you note. We expect these other experiences are influencing responses and as you observe, it is not possible nor necessary in every case to separate the impact of the three-month wait and additional gaps in insurance within our analysis. Instead, our analysis highlights the ways in which this policy compounds other examples of systemic oppression built into health and immigration systems, as demonstrated through the specific experiences of racialized and/or precarious im/migrant women with this policy. We now describe this more clearly under

strengths and limitations, as follows:

“The three-month wait policy is positioned within a larger system of immigration control and health system policy, meaning that necessary limitations exist within this analysis in that we cannot and should not attempt to separate the fact that many women impacted by the three-month wait, also experienced additional gaps in insurance and status delays.” (p. 12, para. 2)

3. In the Discussion the authors state "It is unacceptable that 10 years later our study has identified these same ongoing concerns." This is an opinion (one this reviewer shares). Reframing this opinion in the context of a social responsibility and ethics question is suggested. (e.g. Ethical issues in Women's Healthcare: Practice and Policy. Lori D'Agincourt-Canning and Carolyn Ells; Oxford

We appreciate the opportunity to learn from your expertise in this area. We have amended the framing as suggested and included a reference to the suggested work. It now reads:
“An earlier scoping review of migrants in Canada identified delayed, denied and unaffordable care as key access barriers faced by im/migrants with insecure or precarious status. Our findings show little change and highlight tension produced between immigration policy enforcement in the health sphere and healthcare providers’ ethical and social responsibility to provide care.” (p. 12, para. 1)

4. The selection process for participants may offer study limitations and bias? This should be addressed in limitations. The authors state the women interviewed experienced multiple reasons for their status delays. How certain is it that reasons other than the 3 month provincial delay are not influencing their responses? And their perceptions of harm and their description of the degrading experiences and impacts of public health access to care delays?

As mentioned in #2 above, this comment has improved the strengths and limitations section to 9 ensure this nuance is appropriately captured.

Reviewer 3 (S.C.)

1. Article Summary: Article summary - final bullet point is difficult to follow and I find the claim too broad (all research may not be generalizable to any subgroups). There are also 2 statements here and I don't find that they fit well together. I suggest focussing on either (a) a particular subgroup that was not as well represented in your sample that may limit generalizability to that target group or; (b) the research process, and your particular strategy. for reflexivity - in what ways was it potentially limited? Another limitation I see is depending on community-based organizations to recruit participants. While from a partnered perspective that ensures adequate referrals this is great, from a representation perspective, the researchers could discuss the fact that there may be another group of people who are not linked to organizations or services at all who they were unable to reach in this research.

We appreciate this opportunity to make the summary clearer and have delineated these two points into distinct concepts. We have added language that clarifies the limitation of the sample. The two relevant points in the article summary now read as:

• “Data collection was by a community-based team, most of whom have experienced the same waitperiod.
Analyses were reflexive, led by multiple coders from diverse backgrounds (e.g., Euro-Canadian, racialized women with lived im/migration experience), and informed by “member-checking” in followup interviews and multilingual videos highlighting key findings with participants and ongoing, meetings

and engagement with community partners.

• “Recruitment in collaboration with community partners means that our results may not represent im/migrants who may be more disconnected from community supports.” (p.2)

2. Introduction: Page 4 - I find the framing of paragraph 2 interrupts the flow, as it makes it seem like the article will shift focus to the US before returning to the Canadian setting. Can you finesse this paragraph to fix the interruption in flow?

Thank you for this comment on framing and writing flow. We have edited the US examples to address this issue and improve flow.

3. Introduction: Please remove "entirely" when discussing Ontario waiving period. I find this confusing because it suggests that Ontario has committed to removing the wait period for good, rather than during the current pandemic.

Thanks to this comment and information from another reviewer, we have removed the word “entirely”, along with adjusting the framing to improve accuracy. It now reads: “During the COVID-19 outbreak, the province of Ontario repealed their wait-period policy, with access remaining variable and limited.” (p.4)

4. a) Under the intro section of Methods, I suggest either (1) dropping the phrase about the declaration of helsinki OR (2) elaborating on the particular principles that further characterize the ethical
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protocols of this research from a standard ethical plan (some principles are pretty standard and now considered a low bar, while others may be more aligned with an explicit commitment to health equity)

b) Between the first and second line of "patient and public involvement . . ." subheading there is a tense disagreeement (1st sentence in pressent, 2nd sentence in past). First sentence needs reference at minimum, and ideally, elaboration of what principles these are.

a) Thank you for this important suggestion, this language has been amended to recognize ethical considerations that go beyond Helsinki and that are in line with the community-engaged nature of the project.

b) We have adjusted the wording and grammatical tense accordingly and moved it to the section just above to coincide with the ethics statement that has also been amended. This included adding the relevant principles and reference to the principles followed.

It reads: “The IRIS study draws on principles of community-based research including: iterative community collaboration across all stages of question development, data collection and analysis; a commitment to community advocacy through co-creation of knowledge dissemination products and knowledge translation and exchange with participants, community partners and the broader im/migrant community. IRIS is approved through the Simon Fraser University (SFU) and Providence Health Care/University of British Columbia (UBC) harmonized ethics review boards.” (p. 4)

5. Since bottom of page 5 states that this project is part of larger project. Larger project should be discussed in methods, and then the specific objectives and research Qs of this project should be outlined in relation to the larger objectives of the whole project.

We agree with the need to delineate the larger project and this specific analysis. We think you'll find a much clearer explanation of the larger project throughout the methods section. With the overall project explained further, the stated objective in the introduction stands alone more clearly. This now reads: "Preliminary consultations and focus groups helped shape research questions and priorities for IRIS and included community partners and interested participants in various language (English, Farsi, Dari, Tigrinya and Spanish) and cultural communities. Community partners are listed in the acknowledgements and include community-based organizations offering support services for im/migrants and refugees and government-funded not-for-profit settlement agencies. The focus for this analysis, evaluating the impacts of the three month wait-period, arose from these consultations as well as advocacy work conducted by community partners, made urgent by the COVID-19 crisis." (p. 4)

6. (5) Bottom of page 6 - a description of organizations serving this group would be helpful to understand their reach and track record with the community of interest/

Thank you for this suggestion. Initially this was not included due to space constraints, but we agree it is important detail and have added the following text on p. 4:11
"Community partners are listed in the acknowledgements and include community-based organizations offering support services for im/migrants and refugees and government-funded not-for-profit settlement agencies."

7. (6) Last line, page 6 - who translated? was the research team member bilingual in languages spoken by
participants? Did the person doing the 'check' possess the same language skills? I think this raises more questions the way it is written than it answers. Perhaps better to just say, All interviews were transcribed and translated. (7) In the findings it's made clear that there were language-specific focus groups. It would be helpful for that to be detailed in the methods.

We appreciate the opportunity to clarify this and have described the diversity of language skills within the team more clearly. It now reads: "Interviews were simultaneously transcribed and translated into English by a bilingual team member, followed by accuracy checking by another bilingual team member." (p. 6, para.1)

8. (8) Top of page 7 - References for the analytic method used need to be provided. (9) Here we are introduced again to the 3-month waiting period focus (that to me is only really stated before in the introduction). If this area of focus was developed through the inductive analysis, this needs to be made clear, and it needs to be contextualized in relation to the research question that was first sought (explicitly early in the methods). If it was the main area of focus from the beginning this also needs to be made clear in the methods.

Thank you, we added a reference for the inductive method applied. Additionally, the process through which the focus of this paper was determined (including community advocacy and COVID-19 relevance) is explained in more detail. We hope this resolves the confusion that you have noted here. It reads: "Driven by community advocacy and the urgency of changing policy considerations in BC during the COVID-19 crisis, this study analysis used data previously coded under policies and enforcement, healthcare experiences, immigration status, economic considerations and participant recommendations to explore specific experiences of the three-month waiting period. Interpretation decisions were informed by community through sharing of preliminary results and regular meetings

with community partners." (p. 6, para.2)

9. (10) Last lines before results - I appreciate the transparency of explaining how the team found a fit with intersectionality, but I wonder if for the presentation of the findings, whether it makes more sense to use this analysis to provide a more overarching framing of the findings. I believe this will be easier to follow and be more compelling for readers.

Thank you for this helpful comment. We have woven the application of intersectionality throughout the findings (as much as space permits) to address this comment. You will now find it used as a helpful framing beginning in the introduction and throughout the manuscript including through to the discussion.

10. (11) Page 9 - is "fundamentally unjust" the authors or the participants? If the participants I would suggest reframing to make this clear, such "their best to navigate a system they perceived as unjust." I 12 think it is more powerful to make clear that this was the perspective, as written, it may appear to be editorializing (as much as I agree)

Thank you for this suggestion, this has been removed to ensure there is no concern of editorializing.

11. (12) Top of page 10 presents a contradiction. Authors state ". . . unintended pregnancy . .. common." And then state that ONE participant experienced. This needs to be rephrased, can this be SOME? Or, is it that participants agreed this was a challenge, and one participant detailed her experience going through this?

This phrasing was intended to be used as an example of one person's story. We have adjusted this sentence for clarity and to strengthen explanation of barriers. It now reads: "Multiple experiences of unintended pregnancy due to the lack of contraception arose. Not only was medication coverage its own barrier, but one participant experienced an unintended pregnancy after the wait-period prevented her from visiting a doctor for a prescription to continue on her usual contraceptive method." (p. 10. para. 1)

12. (13) Top of page 11, 2nd paragraph, last sentence needs to be tweaked. The impact of what is being stated is lost because it is hard to follow "One participant reflected on what the point of im/migrating to Canada – a place where most expected "a better life" – would have been if she lost her daughter in the process."

Thank you for this comment, we have adjusted the wording here so that the important emotion and message is not lost. It now reads: "One participant reflected on her hopes for a better life when coming to Canada and how pointless it all would have been if she lost her daughter in the process." (p. 10, para. 4)

13. 14) Top of page 12, suggest introducing the quote while being explicit of the tension, that is, while community support helped ameliorate some of the isolation, barriers remained very real for participants, especially during this wait period

Thank you for this suggestion, this was a powerful change to make and with the framing improved and a different quote used (with the other being moved to the table), the results section is now brought to a clear and concise ending. It reads:
"Instances of newfound communities rallying together to find schools for children, clinics to access

without fear, advice on accessing affordable healthcare, language-specific care and other examples of system navigation support were described as helpful in ameliorating some of the isolation and structural barriers faced during and beyond the wait-period. However, it is clear that regardless of the support accessed, this wait-period remains a very painful barrier for im/migrant women.
I saw the light at the end of the tunnel, the sun came out…when MSP sent me the card, my midwife and I jumped from happiness (Latin American woman, 7.92 years in BC)" (p. 11)
13

14. 15) Please reframe first section, these are not really implications, rather commentary on the findings as they relate to public health. Otherwise, you could merge recommendations with this section, and provide more action-oriented discussion in these sections

We appreciate this honest feedback. This suggestion was helpful in restructuring the discussion section, leaving our recommendations section to be more action-oriented within the context of BC and Canada, as you suggested.

15. (16) First sentence - I would suggest removing or softening this claim. The research findings found a good fit with intersectionality and some mention of it is made, this is not the same as taking an intersectional approach. Also, you did not 'gender' the sample, but rather focussed on the experiences of diverse women.

Thanks for this important comment, this has been removed to better represents the strengths of the study. We genuinely appreciate comments from reviewers that prompted us to further examine the way in which intersectionality was applied in this paper.

16. (17) You have not addressed racism or explicitly sexism in your findings or discussion. If this was the intention, I would go back and weave into these sections, or nuance this claim somehow. I also wonder if this belongs in the discussion section so you can elaborate on this further.

Thank you for this important comment. To address this comment without including identifying information took some creativity, largely because our study collects self-identified ethnicity which is often linked to a country of origin. Given small samples from certain countries, we could not include this specific information to protect participants' identity. However, we looked into some additional information from CIHI (Canadian Institute of Health Information) and explored more creative ways of using ethnicity and race without ignoring the unique experiences of individuals. This can be seen in this sentence added to the participant characteristics section:

"The majority of women in the sample experienced racialization in the predominantly White-European context of BC, identifying with a wide variety of ethnicities (e.g., Latina, Afro/Latina, Black/Caribbean, Black/African, Middle Eastern) that are racialized in Canada." (p.6, para. 4)
Allowing the focus to be on racialization within the predominantly White context of BC improved our ability to discuss structural racism within the findings as well (p. 7-9). An example of this reads

"Women reported facing racism when being asked targeted questions about their immigration status when trying to access healthcare. This was seen through loud and invasive questioning by medical receptionists who doubted their right to access care and portrayed suspicion when deciding who can "access health care and who can die" (Latin American woman, 7.92 years in BC). Experiences like this, where inequities are created by structural hierarchies between residents and "non" residents enforced by the wait-period's exclusion, further attaches race to citizenship." (p. 7-8)

17. (18) it would be helpful to know where "elsewhere" (internationally? other parts of canada?) 14

Thank you for pointing out an area where clarity was lacking. Examples of other contexts where these findings are relevant are discussed in the introduction (i.e., Portugal, France and other parts of Canada), and due to space constraints, we could not repeat them again here. However, we have included an additional reference (that points to one such context) to improve clarity.

18. (19) Without more elaboration on how this research project was reflexive, and how member-checking contributed to a higher level of reflexivity, I don't think there is enough to substantiate how this qualitative project differed from any other that doesn't purport to have a strong level of engagement and community-based analysis. Can you please elaborate. Consider for example, that member checking is a technique that is used across qualitative paradigms, and can be justified for many reasons (e.g. simply for accuracy or triangulation, including "checking if participants are lying")

Thank you for this important critique on our inadequate description of member-checking. In the methods section, this language has been amended to explain exactly what is meant by this to improve clarity as well as ensure no implications of doubting participant experiences: “Community partners provided feedback that shaped the emphasis and focus of data analysis. For participants who requested a second interview, in-depth follow up interviews inviting feedback on common themes and findings were conducted. Common themes and findings were also shared with participants in other ways (e.g., via videos during COVID-19) and participants were invited to share feedback. These two processes allowed for member-checking, where participants could comment on and reflect on the overall findings as well as their experience during the initial interviews. Participants reported feeling comfortable and included throughout this process and supported recommendations to waive the three-month wait period, hoping for policy change in the future.
(p. 4-5, Patient and Public Involvement Statement)

19. (19) Please elaborate on health for all for those who may be unfamiliar and elaborate on how waiving the wait period would be a component of this. I also would suggest being more sparing with quotes here to not lose the impact of what you are saying.

Thank you for this comment. The quotes around “wait-period” and “health for all” were not necessary and have been removed. Working within the word limit, a reference to the WHO definition of health for all has been included for those unfamiliar with the concept.

20. (20) Drop "US" if this is an issue internationally there is no need, and it makes more sense to focus on other countries that have a more similar healthcare system anyway

We appreciate this opportunity to narrow and improve the focus here. We agree with your comment and have removed the reference to the US as suggested.

VERSION 2 – REVIEW

REVIEWER	Young, Charlotte Australian Catholic University, Allied Health
REVIEW RETURNED	24-May-2021

GENERAL COMMENTS	I enjoyed reading this iteration of the manuscript and firmly believe that the findings are important and significant for audiences of BMJ Open. That said, the application of intersectionality theory can be improved. The theory can be more prominent throughout, including by naming intersectionality as the theory of choice in the introduction. There is no explicit mention of intersectionality until describing the analysis in the methods section, which is limited in explaining exactly how the theory was applied (see Marfelt, 2016 for helpful analytical questions to ask of the data: https://doi.org/10.1108/EDI-05-2014-0034). I suggest two options for consideration, 1) that intersectionality be more prominent in every section of the manuscript; with greater attention paid to exactly how the theory assisted the analysis; and how systems of oppression and privilege manifest in the wait-period policy and intersect with the various participants' specific social locations to impact their health uniquely. Alternatively, 2) remove reference to intersectionality as informing the analysis and present the findings as a descriptive study. The points below highlight potential places in the manuscript that option 1 may be attended to and other minor comments for consideration. At the bottom of page 4, beginning of page 5: "Structural racism, the policing of immigration status, poverty and patriarchal structures mean that racialized im/migrant women often face more immediate or severe health and socio-economic challenges in destination settings.19, 20, 21" Here is an opportunity to introduce intersectionality as an appropriate theory that can capture the unique positions of immigrant women as they intersect with systems of oppression and power. The authors can signpost more explicitly when the theory is being used. An intersectional approach is implied here, but I think it can be emphasized by naming 'intersectionality'. Page 7, the authors state that intersectionality was used for the final stages of the analysis. The mechanics of employing this analytical framework could be explained here. It is not clear from the analysis section as it is how this theory has informed the findings. Page 8, lines 19-26: "Im/migrants who face converging effects of gendered power dynamics and the responsibility for children's health, exclusion as a result of racism, precarious immigration status or discordant language experience outcomes distinct from those with privileges associated with male gender, White racialization, secure immigration, and English language communication, which are rooted in patriarchal, racist, xenophobic and colonial power structures." This sentence is unclear and appears unfinished, or perhaps the word 'who' needs to be deleted. This sentence also strikes me as an opportunity to explicitly engage with intersectionality by clearly applying that lens to this summary of the findings. By this, I mean explaining exactly how colonial power structures operate to disadvantage participants (and at which specific intersections) in your study. This detail would strengthen the clarity and rigour of the analysis. The complex processes underway are hinted at but perhaps need

	more words to explicitly apply the theory of intersectionality, which I agree can offer a deeper insight in this analysis. Page 13, lines 29-31: "The author's own reflections on their experience of the wait-period highlighted how structural challenges have a differential impact based on privilege." This statement needs further explanation, as it has not come through strongly in the findings that focus on participants' lived experiences, not the author's reflections.

VERSION 2 – AUTHOR RESPONSE

Reviewer (C.Y.)

1) that intersectionality be more prominent in every section of the manuscript; with greater attention paid to exactly how the theory assisted the analysis; and how systems of oppression and privilege manifest in the wait-period policy and intersect with the various participants' specific social locations to impact their health uniquely. Alternatively,

2) remove reference to intersectionality as informing the analysis and present the findings as a descriptive study. The points below highlight potential places in the manuscript that option 1 may be attended to and other minor comments for consideration.

2) At the bottom of page 4, beginning of page 5: "Structural racism, the policing of immigration status, poverty and patriarchal structures mean that racialized im/migrant women often face more immediate or severe health and socio-economic challenges in destination settings.19, 20, 21" Here is an opportunity to introduce intersectionality as an appropriate theory that can capture the unique positions of immigrant women as they intersect with systems of oppression and power. The authors can signpost more explicitly when the theory is being used. An intersectional approach is implied here, but I think it can be emphasized by naming 'intersectionality'.

Thank you for your helpful suggestions and continued critical eye on the application of intersectionality theory in this analysis. We also very much appreciate the positive feedback on the manuscript and the various suggestions for how to clarify things further. We believe that intersectionality theory is important in framing of the research and interpretation of results, but that this work is most accurately presented as under the second suggested option (i.e., as a descriptive study). Accordingly, we have adjusted the presentation of intersectionality as informing the analysis.

3) Page 7, the authors state that intersectionality was used for the final stages of the analysis. The

mechanics of employing this analytical framework could be explained here. It is not clear from the analysis section as it is how this theory has informed the findings.

In following the suggestion to remove intersectionality theory from the analysis section of this manuscript, the text below highlights the changed framing.

“In the final stages of analysis, MHSG reflexively considered their own experience with the wait

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period as a White Canadian citizen moving between provinces. Sharing some experience with the participants, but in a very different context meant this author consistently returned to participant voices to centre participant experiences and limit the impact of the author’s own assumptions on the findings. While the policy impacts all new residents, elements of privilege like White citizenship produce less exposure to harm compared to the experiences of racialized, im/migrant women, especially those with precarious status. This descriptive analysis highlights these experiences commonly overlooked by dominant power structures. Narrative findings show how health needs specific to sex-assigned at birth, gender-related responsibility for family and children’s health, structural racism, language barriers, poverty maintained by costly health services and immigration processes, and access determined by im/migration status converge to produce disproportionate harm as a result of the three-month wait policy.” (p.7)

4) Page 8, lines 19-26: "Im/migrants who face converging effects of gendered power dynamics and the responsibility for children's health, exclusion as a result of racism, precarious immigration status or discordant language experience outcomes distinct from those with privileges associated with male gender, White racialization, secure immigration, and English language communication, which are rooted in patriarchal, racist, xenophobic and colonial power structures." This sentence is unclear and appears unfinished, or perhaps the word 'who' needs to be deleted. This sentence also strikes me as an opportunity to explicitly engage with intersectionality by clearly applying that lens to this summary of the findings. By this, I mean explaining exactly how colonial power structures operate to disadvantage participants (and at which specific intersections) in your study. This detail would strengthen the clarity and rigour of the analysis. The complex processes underway are hinted at but perhaps need more words to explicitly apply the theory of

intersectionality, which I agree can offer a deeper insight in this analysis.

Thank you for your work and attention to this detail. The grammatical errors have been fixed and this explanation further clarified. Please see the revised text:

"Im/migrants face converging effects of exclusion resulting from racism, precarious im/migration status and discordant language experience. Im/migrant women experience all of this in addition to the effects of gendered power dynamics and the responsibility for children's health. These outcomes are distinct from those with privileges associated with male gender, White racialization, secure immigration, and English language communication, which are rooted in patriarchal, racist, xenophobic and colonial power structures. The intersecting effects of gendered racism and exclusionary im/migration policy manifest in the health system to produce - disproportionate harms for im/migrant women in this sample." (p. 8)

5) Page 13, lines 29-31: "The author's own reflections on their experience of the wait-period highlighted how structural challenges have a differential impact based on privilege." This statement needs further explanation, as it has not come through strongly in the findings that focus on participants' lived experiences, not the author's reflections.

Thanks for this comment. We hope that the changes undertaken above will address your concern. Therefore, this section of text has been removed to not add further confusion.

VERSION 3 – REVIEW

REVIEWER	Young, Charlotte Australian Catholic University, Allied Health
REVIEW RETURNED	19-Jul-2021

GENERAL COMMENTS	The manuscript maintains its clear and important focus on the inequities experienced by im/migrant women in relation to healthcare access and outcomes. While the associated intersecting systems of oppression and privilege manifest in this wait-policy are highlighted in this work, the application of an intersectional analysis is no longer in question. These important findings are worthy of publication and I have no further comments on the manuscript. Thank you for this rewarding exchange.