UNDERGROUND PATCHWORKS OF ACCESS: MIGRANT HEALTH ACTIVISM IN ONTARIO AND THE EMOTIONAL WORK OF STORYTELLING AND DESERVINGNESS

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Abstract

Migrants with precarious immigration status often face significant structural and institutional barriers to accessing healthcare in Ontario. These include discrimination, racism, and financial constraints, which often generate fear and mistrust of healthcare institutions. In the absence of formalized policies and practices, community organizers, front-line workers, and civil society members with lived experiences of precarious status—referred to here as "activists"—navigate an (in)visible "underground patchwork" of access. They do so amidst an increasingly privatized and restrictive healthcare landscape. Through this work, activists not only support migrants to access care but also challenge systemic exclusions and health inequities.

This dissertation examines how Ontario migrant health activists use de/bordering strategies to negotiate healthcare access for individuals with precarious status. It focuses on the emotional work involved in this advocacy, exploring how activists navigate shifting (institutional and interpersonal) contexts, manage emotional challenges, and adapt their de/bordering efforts accordingly.

Using discourse analysis, I analyze 47 in-depth interviews and institutional/governmental health documents. Drawing on interdisciplinary literatures in bordering studies, social movement theory, and affect scholarship, I analyze how storytelling, emotions, and context shape migrant health advocacy. This approach calls for a non-binary and multi-dimensional understanding of deservingness, one that reflects the complex, context-dependent, and sometimes paradoxical nature of deservingness, that goes beyond debates in current scholarship.

Activists' stories—shaped by evolving contexts and emotional responses—inform their de/bordering strategies. Their emotional work is sustained through coalition-building and solidarity efforts, which help them cope with distress and foster relationships that, in turn, shape their advocacy strategies.

I argue that by telling stories shaped by emotional experiences and shifting contexts, activists iteratively construct non-binary understandings of deservingness and challenge dominant discourses and power structures. Their de/bordering strategies evolve across socio-political and emotional contexts, using storytelling (Chapter 5), informal knowledge-sharing (Chapter 6), and coalition-building as both advocacy and emotional support (Chapters 7–8).

This dissertation contributes to bordering scholarship by offering empirical and theoretical insights into how de/bordering strategies are enacted in migrant health advocacy and how emotional and contextual shifts shape activists' work. I examine how activists negotiate healthcare access while navigating exclusionary im/migration and health regimes. In doing so, I bring de/bordering as a concept into conversation with broader dynamics of differential inclusion and expand the literature by developing a framework attuned to the complexity of deservingness assessments in this field.

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Chapter 1: Introduction

If the [PHSUP] policy had not existed, "there's a very real possibility that the first time I would have seen that child would have been in the ICU or in the emergency room or worse, not at all" (OMA, 2023)[1]. Dr. Suleman recalls seeing a young boy who had just arrived in Canada as a refugee claimant with his family. The little boy showed signs of a serious, untreated genetic condition affecting his blood and heart. Having never seen a doctor before, his serious condition had gone unnoticed. Realizing the urgency, Dr. Suleman acted quickly, organizing blood tests and appointments with specialists to get him the care he needed.

Dr. Suleman was able to treat this little boy and others in the refugee shelter (and be paid for this work) through a temporary policy introduced in March 2020 by the Ontario Ministry of Health called the Physician and Hospital Services for Uninsured Persons Program (PHSUP) (Government of Ontario, 2021a). Under the "PHSUP policy," everyone in Ontario was to have access to "medically necessary" health services, without cost, regardless of immigration status. Introduced as a temporary pandemic measure, this policy helped facilitate care for many who otherwise would not be eligible. However, the policy's impermanence raised concerns among many activists and advocates[2], including Dr. Suleman, who feared that without a permanent policy, the access facilitated by PHSUP could be rescinded at any moment, reinstating exclusionary systems and requiring renewed advocacy and activism to secure care.

In March 2023, those fears materialized when the Ontario government revoked the PHSUP policy. Once again, individuals with precarious immigration status—including international students, temporary workers, refugees, visitors, and non-status individuals—faced renewed exclusion from healthcare access, subject to discretionary policies and practices that do not consistently result in access and left to fight to qualify as deserving of care. As Dr. Suleman put it: "The day it was announced the [policy] would end, I felt physically sick thinking of the children who don't have insurance. They're not just numbers. I see their faces in my mind and my heart is breaking."

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[1] Ontario Medical Association. (2023, July 19). *Ontario doctors urge government to create permanent program for uninsured patients* https://www.oma.org/news/2023/july/ontario-doctors-urge-government-to-create-permanent-program-for-uninsured-patients/

[2] While both terms appear throughout the dissertation, I describe participants primarily as "activists" to describe their full spectrum of political actions (Mainey et al., 2025), from broader-scale efforts, to smaller-scale, day-to-day, or quiet forms of advocacy.

Dr. Suleman's reaction underscores the magnitude of the policy's revocation, signaling a return to a healthcare system that systematically excludes migrants from equitable access. Her response reflects the fear and urgency expressed by activists who publicly criticize Ontario's increasingly restrictive healthcare environment. Following the policy's revocation, another activist, Dr. Goel, noted that she and others began hearing "similar stories again" of care denials and gatekeeping, suggesting that the harms they had feared were already unfolding (OMA, 2023). For example, she described her pregnant uninsured patient "being asked for cash while in labour," an elderly man with a serious infection being forced to leave the emergency department because he could not pay, and a middle-aged man whose family "had gone into debt back home so he could access a surgery for his tumour."

The revocation of the PHSUP policy is not an isolated incident but part of a broader pattern of systemic inequities in Ontario's healthcare system, through which migrants with precarious immigration status are disproportionately impacted. Compared to citizens and permanent residents, they face reduced access to care and worse health outcomes (Gagnon et al., 2021). They are also more likely than citizens and permanent residents to be triaged into severe categories upon arriving in hospitals (Garasia et al., 2023), including facing higher obstetrical complications, needing resuscitation, and dying upon arrival to the emergency department: "5.6% vs. 2.7%, 15.6% vs. 11.2%, and 3.7% vs. 2.8%, respectively" (Hynie et al., 2016). Because individuals with precarious immigration status avoid seeking healthcare in light of exclusionary policies and practices, they tend to delay treatment until their conditions worsen, contributing directly to these inequities and disparities in outcomes (Gagnon et al., 2021; Garasia et al., 2023).

These worsened health outcomes are compounded by continued challenges within the Canadian healthcare system, including inadequate access to primary care, long wait times, and a lack of mental health services (Canadian Institute for Health Information [CIHI], 2024). While these issues affect the general population, they have especially harmful effects on migrants with precarious immigration status, whose access to care is shaped by overlapping forms of marginalization, including racialization, gender, and immigration-related exclusions (Goldring et al., 2024; Molenaar & Van Praag, 2022; Moroz et al., 2020). Migrants are often excluded from public health insurance, face high costs when seeking care, experience racism and discrimination

in healthcare settings, and fear immigration enforcement—all of which deter them from accessing care in a timely manner (Gagnon et al., 2021; Garasia et al., 2023; Hynie et al., 2016). These systemic barriers not only limit access but can lead to delayed treatment, severe illness or even death (Gagnon et al., 2021; Garasia et al., 2023; Hynie et al., 2016). Together, these structural barriers deepen existing health inequities and contribute to disproportionately poor health outcomes for migrants.

The removal of the PHSUP policy is one example of ongoing equity challenges and a broader shift toward a more restrictive healthcare landscape in Ontario. Other developments, such as the privatization of healthcare and funding cuts that have led to healthcare worker layoffs, reflect this trend (Armstrong and Armstrong, 2023). These changes mark a departure from presumed universal access, moving toward increasingly limited care, especially for those most marginalized, including migrants (Hedden, 2023).

In this context, migrants must navigate restrictive and exclusionary bordering practices that shape processes of differential inclusion. As I discuss in more detail below, bordering refers to the processes by which inclusion and exclusion are mediated through laws, discourses, and everyday practices. Differential inclusion refers to the blurring of boundaries between inclusion and exclusion in bordering spaces (Casas-Cortes et al., 2014; Mezzadra & Neilson, 2012; Segrave, 2019). Specifically, Mezzadra and Neilson (2012) refer to it as the ways in which "inclusion in a sphere can be subject to varying degrees of subordination, rule, discrimination and segmentation" (p. 67). Notably, Segrave (2019), whose work looked at the context of Australian "unlawful" migrants and their employers, expands this concept by arguing:

> Nation-state's efforts to demarcate non-belonging and exclude by law and policy implementation are persistently destabilized – through everyday place and practices of both citizens and noncitizens. These experiences and practices are not just sites of struggle, but also the embodiment of inclusionary bordering practices that disrupt the overarching nation-state goal of exclusion (p. 195).

As Segrave (2019) suggests, these dynamics are reproduced and disrupted through exclusionary health and im/migration laws and policies, as well as through inclusionary strategies employed by migrants and those who support them. In response to these compounding exclusions, activists like Dr. Suleman have created what scholars refer to as a "patchwork" of access (Landolt, 2022) – informal arrangements that bridge the gap between formal rights

granted in laws and policies and the substantive access to care in practice. Participants also described these networks as "underground cultures of goodwill" (Poppy, Nurse) and "underground patchworks" (Vivian, Nurse), highlighting the relationships and forms of reciprocal support they mobilized to secure care. I build on these perspectives to define underground patchworks as informal care networks – sometimes visible, often (in)visible – through which activists work across institutional and community settings to negotiate access to healthcare for those they support.[3] I use the term "work" to refer to not only the more visible forms of labour, such as the time and resources put into activist work, but also to the less visible emotional work involved in sustaining relationships, navigating tensions, and persisting in the face of systems that continuously reproduce exclusion (Gauditz, 2024). Emotional work refers to the substantial affective effort activists invest, particularly as they navigate exclusionary healthcare systems and foster networks of support. While emotional work (or labour) has largely been examined in the context of paid street-level actors, recent scholarship has extended this concept to unpaid activist labour, highlighting how emotional work sustains advocacy, and is shaped by intersectional factors, including racialization, gender, socioeconomic status, and immigration status (Blais, 2023; Kleres & Wettergren, 2017; Snow, Kilty, & Gervais, 2024).[4]

This dissertation uses the term "activists" to describe participants' activities across a spectrum—including quieter forms of action within institutional spaces (filing paperwork, making phone calls, accompanying migrants to appointments) often called advocacy, and public engagement in broader mobilizations (attending rallies, raising awareness), often called activism. Advocacy and activism represent a spectrum of political action aimed at social or political change (Mainey et al., 2025, p. 980). While these terms are often used interchangeably, activism typically involves more radical or system-challenging actions, whereas advocacy focuses on amplifying the voices of affected communities in ways that are considered diplomatic or

[3] Because this work is informal, fragmented, and often hidden, it can be difficult to stitch together and fully grasp. Participants described how they must keep parts of their work discreet, avoiding best practice sharing or organizing too visibly to avoid increased immigration scrutiny. I use the term (in)visible – in brackets – to reflect how this work is at times public but more often negotiated discreetly, enabling activists to secure care without calling attention to the work. This protective (in)visibility, while necessary at times, limits possibilities for collective resistance, systemic change, and efforts to challenge health inequities resulting from differential inclusion (discussed in detail in Chapter 6).

[4] Others who have described activism as a form of emotional labour include: (Humphrey, 2022; Jacobsson & Lindblom, 2013; Reger, 2004; Rodriguez, 2022; Williams et al., 2019; Wyatt & Ampadu, 2022). However, more generally, emotional labour research is focused on the emotional management of paid street-level actors in frontline roles, of which Arlie Hochschild's (2012) work on emotional labour and emotion work (1979) is often referenced.

institutionally acceptable (Mainey et al., 2025). Advocacy often influences, and activism can overhaul (Mainey et al., 2025). For the purposes of this dissertation, I treat both as part of a continuum of political actions but use the term "activists" primarily throughout to describe the full range—from "day-to-day" or "quiet" activism to more visible, system-challenging forms.

Within these patchworks, activists—including doctors like Dr. Suleman, lawyers, community organizers, administrative staff, and others—work as navigators and guides. In social movement literature, this work is often described as collective actors' "repertoires of action," which are spatio-temporally dependent: their makeup and practice are shaped by where and when they unfold (Wood, 2024, p. 15). For example, institutional constraints, relationships among actors, and the emotional responses of activists at particular moments in time all influence how repertoires are developed and enacted. I refer to this work as "emotional de/bordering work" to emphasize that activists' efforts are shaped not only by strategic responses to structural exclusions, but also by their deeply felt emotional responses to the social and relational contexts in which they are embedded.

While activists use a range of de/bordering strategies – defined here as practices through which they negotiate healthcare access and challenge exclusionary healthcare systems, – I focus on three used by participants in this dissertation: storytelling, which refers to how activists make sense of and communicate ideas of migrant deservingness, both internally and publicly to secure care; creative negotiation tactics used to navigate institutional and structural constraints; and relationship-building through coalitions and practices of solidarity.

In my analysis, I draw on and expand Segrave's (2019) arguments about differential inclusion as sites and strategies of struggle. In her work, Segrave (2019) argues that, within the exclusionary constraints set out by nation-states, these inclusionary strategies aim to transform laws and policies designed to exclude, creating "alternative space and forms of inclusion, and indeed, protection" (p. 197).

My analysis engages with Segrave's (2019) conception of differential inclusion by bringing de/bordering strategies into this conversation, namely the often underemphasized, emotional and contextual (interpersonal and institutional) dimensions of this activist work. By analyzing how these dimensions shape activists' work, and bringing a non-binary, multi-

dimensional approach to understanding deservingness as it pertains to de/bordering, I contribute to a more nuanced understanding of migrant health advocacy within bordering studies.

Unlike existing scholarship, which primarily focuses on structural dynamics, I foreground the emotional and contextual dimensions that shape how activists assess migrant deservingness as part of their de/bordering work. While "deservingness" is often treated as a fixed, binary judgment (deserving/undeserving), in this dissertation, I argue that activists engage in the context-specific, emotionally charged, and relational processes of meaning-making that inform non-binary and dynamic conceptions of deservingness. Storytelling is central to this reconceptualization, challenging dominant discourses and reshaping ideas of who should have access to care. I aim to bring this contextual, emotional, and narrative work to the foreground as a vital yet underexamined dimension of bordering activism.

I examine the inner workings of this patchwork of access to understand the emotional de/bordering work of activists: including what they do, how they do it, how doing it affects them, what they need to do the work effectively, and what is needed to change the system to reduce the demands placed on them. Together, these analytic lines of inquiry form my central research question. This analysis contributes to a nuanced understanding of the dynamism of differential inclusion, de/bordering, bordering (and re/bordering – discussed in Chapter 2), showing how activists engage in emotional work to challenge exclusion while also managing emotional distress along the way. This analysis urges bordering scholars to better account for the emotional and often (in)visible forms of labour through which resistance occurs.

I draw on the concepts of bordering, de/bordering, storytelling, deservingness, and emotion to examine how activists navigate exclusionary healthcare systems. I analyze how they use storytelling, creative negotiation, and relationship-building to challenge power relations and reframe ideas of migrant health deservingness.

Bordering refers to the organized structure by which social and political order is controlled through "ideology, cultural mediation, discourses, political institutions, attitudes and everyday forms of transnationalism" (Bendixsen & Näre, 2024; Yuval-Davis, Wemyss, & Cassidy, 2019, p. 229). This process determines "who is and who is not entitled to enter the country, but also whether those who do would be allowed to stay, work, and require civil,

political, and social rights" (Yuval-Davis, Wemyss, & Cassidy, 2019, p. 5). In healthcare contexts, these bordering practices determine eligibility for care and the conditions under which it is provided.

I also use the concepts of stories, storytelling, and narratives in this dissertation. Through storytelling, activists expose the institutional and structural barriers that migrants with precarious immigration status face in accessing healthcare. In recounting their experiences, as Dr. Suleman does when reflecting on caring for the young boy, activists draw attention to these barriers and take on vital roles in navigating and challenging exclusionary systems (Artero, 2024; Dimitriadis et al., 2021). These stories evoke emotional responses that resonate more deeply than data or policy analysis. As activists engage in the iterative process of telling stories, they can disrupt dominant discourses around those seen as "deserving" of access to healthcare.

I use "stories" and "narratives" interchangeably, recognizing the distinction as blurred[5] (Frank, 1995, p. 188; Polletta, 2006). Stories (narratives) are defined as having a minimal plot with a beginning, middle, and end, set within specific contexts and often involving a moral element (Polletta, 2006; Polletta et al., 2011). While I ground my understanding of stories in this formal definition, I adopt a broader analytic lens in my analysis. I examine how participants not only shared extended, temporally sequenced narratives but also drew on fragments or emotionally resonant moments that did not always follow a classical narrative arc. These partial stories often emerged gradually, across our conversations, and can be understood as performing similar narrative work, shaping how deservingness is understood, negotiated, and contested in migrant health advocacy.

I understand stories as providing activists with a powerful toolkit to challenge and disrupt dominant power structures that reproduce a deservingness for some and not others. While I have made choices about which fragments of participants' accounts to include here, many shared fuller narratives that unfolded over the course of the interviews. However, these often unfolded gradually throughout our entire conversations. My analytical approach involved using discourse analysis to identify moments when participants engaged in storytelling as a creative and sometimes strategic practice. These often included emotionally charged reflections on navigating

[5] While I follow Frank's (1995) interpretation, which treats stories and narratives as overlapping, many scholars draw distinction between the two (e.g. Somers, 1994).

assessments of deservingness and shifting their advocacy work across institutional and interpersonal contexts. From this perspective, I understand storytelling as central to activists' de/bordering work—it is a key strategy they use to navigate exclusions, make sense of their experiences, and negotiate access to healthcare.

Deservingness is another central concept I use in this dissertation. In the context of migration and healthcare, deservingness assessments are often shaped by citizenship status, moral judgments, and access to rights (Ambrosini, 2022; Carmel & Sojka, 2021; Chauvin & Garcés-Mascareñas, 2014; Holmes et al., 2021; Huschke, 2014; Ratzmann & Sahraoui, 2021; Willen & Cook, 2016). Broader legal and socio-political factors typically shape these assessments and are used to determine who is considered 'worthy' or 'unworthy' of care. As mentioned, my reconceptualization of deservingness helps make visible the role of stories and emotions across diverse contexts as key dimensions of activist work. Specifically, I explore how activists use stories of deservingness and make decisions about how they engage in de/bordering practices, often experiencing emotional tension and a range of interpersonal and institutional contexts.

Finally, emotion is a key concept in this dissertation. I use the terms 'emotion' and 'affect' interchangeably, following Sara Ahmed's (2006) understanding of emotion as an integral part of affect, where affect is understood as part of what emotions do. Together, these concepts are useful for examining how individuals move through and negotiate relationships across various contexts (Schmitz & Ahmed, 2014). I draw on emotion (affect) to gain insight into activists' feelings about their work, ways of engaging in it, and forms of distress they experience during their work.

Research Questions

Building on this conceptual foundation, this dissertation examines how activists in Ontario navigate the complex im/migration and healthcare landscape to support individuals with precarious immigration status. I approach this through the lens of emotional de/bordering work, focusing on the strategies activists use across a range of institutional and interpersonal contexts, and how they are affected in their efforts to negotiate access. This dissertation is informed by a feminist approach that centers emotional, intersectional experiences and relational contexts.

Activists' work is informed by a dynamic, iterative process in which context, emotional resonance, and narrative practices shape and are shaped by their ongoing efforts. To explore this process, I ask the following sub-questions: 1) How do activists' de/bordering strategies evolve in response to structural and institutional barriers, emotional challenges, and shifting contexts? 2) What tools and supports do they need to carry out this work effectively? 3) How do they manage the emotional demands of their work, including emotional distress?

To address these research questions, in Chapter 2, I review existing scholarship on bordering, social movements, and feminist affect theory. I also draw on interviews with activists and examine Ontario institutional and governmental health documents. Details of the interview data (collection and analysis) process and review of health documents are discussed in Chapter 4. These empirical elements help me build my conceptual framework to show new ways of understanding deservingness that reflect the emotional, narrative, and contextual dimensions of migrant health advocacy. This includes the stories activists tell, the decisions behind which stories are told and when, and how both narratives and underlying emotions inform activists' strategies and perceptions of deservingness.

While this dissertation focuses on the Canadian context, the issues of healthcare access, entitlements, and negotiation are globally significant. Many countries, including Canada, present a façade of universal healthcare, guaranteeing rights on paper while failing to provide meaningful access in practice. As formal systems fall short, activists step in to fill critical gaps. Their work is especially important amid increasingly restrictive health policies and austerity measures worldwide. These activist efforts shed light on how differential inclusion governs who is granted or denied care, particularly for those with precarious immigration status and other marginalized groups. Examining how activists navigate these uneven landscapes offers crucial insight into the complex and negotiated pathways through which access to healthcare is pursued.

Healthcare access is influenced by a contested social field subject to ongoing negotiation, exclusionary health and im/migration laws and policies, and inclusive bordering efforts that shape and challenge dominant ideas of belonging and deservingness. In Canada, significant discrepancies exist between formal and substantive citizenship, both of which shape access and entitlements to many social services (Chen, 2020; Ratzmann, 2022). Formal citizenship, which

confers rights, including healthcare access, is often tied to legal status granted to citizens and permanent residents (Chen, 2020). In contrast, substantive citizenship refers to "informal claims to social belonging," which impact social, economic, and political inclusion (Chen, 2020, p. 5). Understanding negotiated access through the lens of de/bordering efforts helps to illuminate how activists respond to these exclusionary processes of differential inclusion. Activists play a key role in navigating and reworking these dynamics, revealing how access to care is pursued, denied, and reimagined in spaces of exclusion.

Contributions

In this dissertation, I make three key contributions to existing bordering scholarship:

1) Contribution to the Study of Bordering and Migrant Health Advocacy

This dissertation contributes to bordering scholarship by analyzing how activists de/bordering strategies are shaped by their context, namely their relational, emotional, and institutional/structural contexts. Drawing on insights from feminist affect theory and social movement research, I foreground the emotional and contextual dimensions of bordering processes, specifically how activists' de/bordering work, such as storytelling, informal strategizing, and coalition-building, allows them to challenge structural inequities in healthcare and negotiate access for migrants with precarious immigration status. This approach expands bordering scholarship by showing how activists' resistance work is informed by emotions, stories, and relational practices often overlooked in current migrant health advocacy research.

2) Contributing to Analyses of Differential Inclusion, De/Bordering Work, and Deservingness

A second key contribution is the reconceptualization of "deservingness" as a multi-dimensional and non-binary concept. In contrast to fixed or binary framings (e.g., deserving vs. undeserving), I show how activists draw on various deservingness narratives, iteratively, creatively, and strategically engaging in de/bordering efforts while navigating the emotional and contextual dimensions of their work. This reconceptualization deepens theoretical understandings of deservingness and de/bordering while offering practical insight into how activists challenge structural and institutional exclusions in their work. In doing so, this case study of migrant health activism contributes to a dynamic understanding of differential inclusion by specifically examining the role of activists' de/bordering strategies within processes of differential inclusion.

3) Analyzing how Activists Manage Emotional Distress Through Solidarity and Coalition-Building

Lastly, drawing on social movement and bordering literature, I contribute to scholarship on bordering activism by examining how activists manage the emotional distress that emerges in their work. While research has explored emotion in collective action more broadly (e.g., Van Ness & Summers Effler, 2018), the role of emotion in bordering activism remains underexamined, particularly in relation to stories, deservingness, and health exclusion (Jawed et al., 2021; Olcoń & Gulbas, 2021). I extend this research by showing how the emotional toll of this advocacy can generate distress, and how activists respond by building relationships, coalitions, and practices of solidarity to sustain their work.

In addition to these scholarly contributions, this dissertation offers practical insights for activists. By centering the emotional and contextual dimensions of advocacy, it provides language and frameworks that support activists' meaning-making, creative strategizing, and relationship-building, particularly in contexts of restriction or constraint.

Dissertation structure

The structure of the dissertation is as follows:

In Chapter 2, I provide background on migrant health advocacy in Ontario, focusing on access to care and entitlements for individuals with precarious immigration status. I also review relevant scholarship, drawing from bordering studies, social movement research, and feminist affect theory, to lay the groundwork for the conceptual framework developed in Chapter 3.

In Chapter 3, I present this conceptual framework, reconceptualizing deservingness as non-binary and multi-dimensional, rather than a fixed moral or legal category. I draw on multiple literatures to show how activists' emotional responses and shifting contexts shape their work and how they engage with stories of migrant deservingness. This chapter addresses my research questions by offering analytic tools to examine activists' emotional de/bordering work and their deservingness assessments.

In Chapter 4, I outline the methodological approach I use to guide my qualitative interviews with 47 migrant health activists and my review of health documents. I outline my

thematic and discourse analysis approach and discuss ethical and logistical challenges I encountered, including positionality and trust-building.

Chapters 5 through 8 form the core of my empirical analysis. Drawing on interviews and health documents, I examine how activists negotiate access to healthcare, reshape ideas of deservingness, and manage the emotional burden of their work.

In Chapter 5, I examine how activists use storytelling to challenge dominant narratives of deservingness that contribute to migrants' exclusion from healthcare. I analyze the multiple stories activists draw on across different contexts and in response to their emotional experiences. I argue that they engage dominant (familiar), counter-discursive (meaning countering-dominant discourses and familiar stories of deservingness), and ambivalent narratives (marked by emotional tension when drawing on familiar and counter-discursive narratives), and that various forms of compassion (including sentiments of humanitarianism and/or solidarity) shape how these stories are constructed and conveyed. This chapter addresses my research questions by showing how activists negotiate access through storytelling, one of the central strategies of their work, which helps them make sense of, creatively build, and communicate complex, evolving narratives of migrant deservingness.

In Chapter 6, I investigate how activists use this patchwork of access informal networking, praxis (how their advocacy is put into practice through experience and reflection), and social learning (understandings built from cumulative experiences and relationships) strategies to navigate exclusionary health and im/migration systems. I analyze how these strategies allow activists to work creatively within structural constraints and argue that, while such approaches may sometimes reproduce dominant narratives, they remain essential for securing care when formal access is denied. This chapter addresses my research questions by showing how activists use these strategies to negotiate access.

In Chapter 7, I examine the coalition-building and solidarity strategies that activists use in their advocacy work. I explore how these strategies help activists build emotional resilience, strengthen relationships, and develop collective practice. This chapter addresses my research questions by examining the broader advocacy strategies (such as building relationships and going to rallies) that activists use and the knowledge produced and fostered in the process.

In Chapter 8, I examine the situational challenges associated with this work and how activists manage emotional distress in the face of institutional and systemic barriers. Building from the analysis in Chapter 7, I argue that activists manage emotional distress through their solidarity and coalition-building, which helps them feel connected to a greater cause and allows them to resist internalizing structural barriers as personal failures. In this chapter, I address research questions about how activists manage emotional distress and the necessary tools to sustain their work.

Finally, in Chapter 9, I revisit my central research questions and synthesize the dissertation's key findings, showing how activists navigate and rework dominant narratives of deservingness through emotional de/bordering practices. I return to the concepts of differential inclusion, de/bordering, storytelling, and deservingness to reflect on the strengths and limitations of the non-binary, multi-dimensional way of understanding deservingness developed throughout the dissertation, considering the broader implications of this analysis for future research, policy, and activist scholarship.

Chapter 2: Context and Literature Review

In this chapter, I review the literature to situate and inform my analysis of how migrant health activists engage in de/bordering work. Prior to conducting the review, I provide context on healthcare access in Ontario, focusing specifically on the barriers faced by migrants with precarious immigration status. I also discuss the history of migrant health activism in Ontario to offer a clearer picture of the structural and institutional conditions that activists navigate. The historical context is essential for understanding the resistance strategies activists have used over time, which continue to inform their work today.

Background: Setting the Stage for Activists' De/bordering Work

Bordering literature increasingly views borders not as fixed lines, but as "multidimensional bordering processes" (Sendhardt, 2013, p. 21). Within this framework, re/bordering refers to efforts to tighten borders, such as increased controls or the re-territorialization of space, while de/bordering involves processes that increase border permeability (Rumford, 2006; Sendhardt, 2013). Importantly, these are not in strict opposition to each other. Sendhardt (2013) argues that re/bordering can be part of the broader, dynamic process of de/bordering.[6] Similarly, Dimitriadis and Ambrosini (2022) highlight how street-level actors seeking to de/border – by negotiating social services for migrants – may unintentionally re/border, reinforcing exclusions they aim to challenge.

Thus, while re/bordering usually denotes explicit, intentional border reinforcement, de/bordering captures complex, often non-linear efforts to negotiate access and inclusion, efforts that may simultaneously or inadvertently contribute to re/bordering. This dynamic interplay reflects ongoing negotiations of inclusion and exclusion (and thus can contribute to the dynamism of differential inclusion), where practices of de/bordering are often entangled with re/bordering.

In this dissertation, I build on this nuanced understanding of de/bordering to analyze how street-level actors' efforts both challenge and reinforce borders within exclusionary systems.

[6] As translated in Sendhardt (2013): "Rebordering can be viewed as: as social phenomena within the framework of an overall debordering of the world of states, […] as a specific reaction to the debordering processes that are actually taking their course within the framework of globalization. Viewed in this light, demarcation (rebordering) would be, first and foremost, a way of regulating the process of transformation, not of arresting it" (Albert/Brock, 2000, p. 42).

De/bordering, in this sense, does not always lead to clear or even desirable outcomes but instead forms part of a broader, multi-dimensional and sometimes paradoxical bordering process.

In this section, I review and map out the current context of activists engaging in their de/bordering work. This includes a brief review of the healthcare entitlements for individuals with precarious immigration status at specific moments, including during and after the COVID pandemic, to explore the role of activist work in influencing this healthcare access.

An important consideration regarding the terminology of access and entitlement used in this dissertation is the recognition that entitlement does not necessarily translate into access for those with precarious immigration status. This is due to additional challenges, including fear of deportation, cultural and linguistic barriers, poor or misinformed information on the part of some gatekeepers, discrimination, and difficulties navigating the healthcare system (Gagnon et al., 2021).

Before the COVID pandemic, people with precarious immigration status had very limited access to healthcare services, and often none at all. The removal of policies like the PHSUP policy has exacerbated these existing inequities (Brophy et al., 2023; Janzen, 2023). While the PHSUP policy was initially introduced as a temporary, emergency response to the COVID pandemic, not explicitly intended to address migrant health inequities, its rollback, alongside the increasing privatization of healthcare in Ontario, nevertheless underscores persistent gaps in equitable access to healthcare for marginalized populations, including migrants with precarious immigration status within the healthcare system (Armstrong & Armstrong, 2023).

With the removal of the PHSUP policy, individuals with precarious immigration status once again face limited formal entitlements to healthcare and even less access. Activists have been crucial in challenging these systemic inequities, pushing back against healthcare privatization and advocating for the reinstatement of the PHSUP policy. Through their de/bordering work, they engage in actions to support migrants with precarious immigration status in navigating these exclusionary bordering spaces and/or pushing for broader structural changes. Currently, individuals with precarious immigration status have minimal access to healthcare services through Community Health Centres (CHCs) or hospitals. Moreover, they are required to pay out of pocket at hospitals.

Despite the increasing number of individuals with precarious immigration status in Canada, healthcare access and entitlements have not grown proportionally to meet their needs. Estimates suggest there were between 20,000 and 500,000 non-status individuals in Canada as of 2006 (Jimenez, 2006). Although precise current figures are lacking, it is known that the number of people working in Canada with precarious immigration status has risen steadily over the past two decades due to the increase in temporary entrants (CCR, 2023; Triadafilopoulos & Taylor, 2024). This growth, however, has not been accompanied by improvements in healthcare access and entitlements. As a result, a significant portion of Canada's population still lacks formal health coverage and practical access to healthcare services.

The interaction between im/migration categories and entitlements to healthcare coverage significantly impacts access. There are also major gaps between governmental and institutional laws and policies that determine healthcare eligibility, and the implementation of these laws and policies in practice (Chase et al., 2017; Ruiz-Casares et al., 2010; Watters, 2011). The process for determining eligibility for healthcare services varies depending on an individual's immigration status. For instance, refugees covered by the Interim Federal Health (IFH) program, international students with limited university or college (CIHIP) plans, and temporary migrant workers eligible for the Ontario Health Insurance Plan (OHIP) experience differing access to and entitlements for healthcare coverage (CIHIP, 2023; UHIP, 2023). Temporary work permits can include closed work permits, in which an individual's immigration status is tied to employment with a specific employer (Hennebry et al., 2015). People considered 'non-status' do not have authorization to live or work in Canada; they are not entitled to any healthcare coverage and must pay out of pocket for all healthcare services they receive. How individuals become uninsured, including having their refugee claims rejected and during spousal sponsorship breakdowns, is shown in Figure 1.

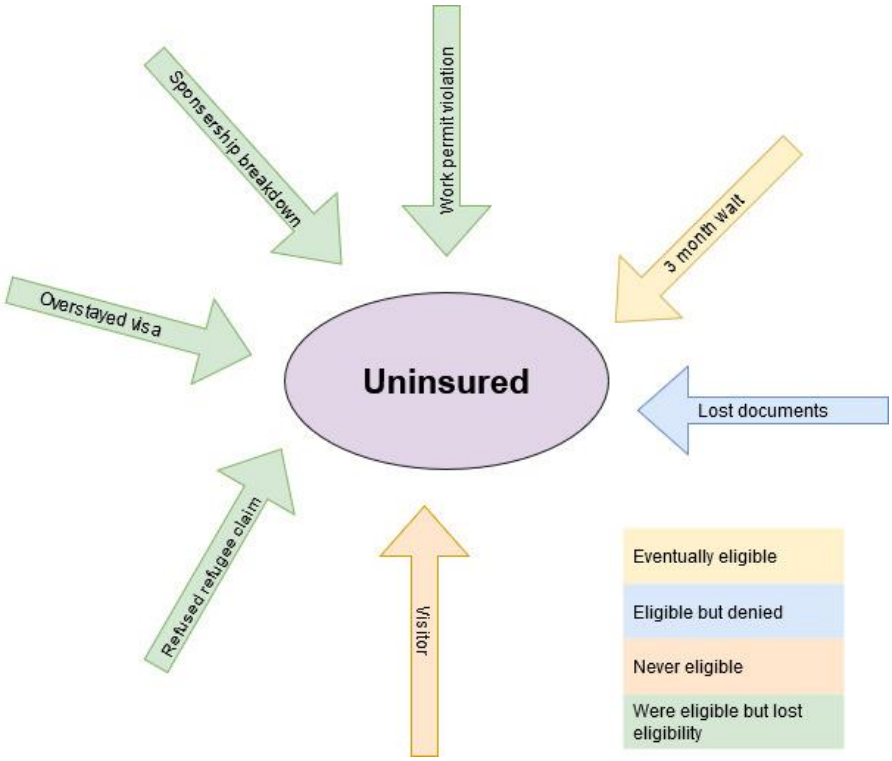

Figure 1: How People Become Uninsured. Adapted from Michaela Hynie (2016, p. 3)

While technically eligible to receive healthcare services if they pay out of pocket, non-status individuals face multiple barriers to healthcare access. Some barriers are directly related to non-status migrants' experience of exclusion and precarity, including fear of deportation, discrimination, and the inability to pay for healthcare (Gagnon et al., 2021). These migrant-side barriers often exacerbate challenges in accessing healthcare. At the same time, systemic barriers – those rooted in institutional practices, discretionary decision-making by street-level actors, and broader affordability issues within the healthcare system itself – play a significant role in limiting access to care (Gagnon et al., 2021). While non-status individuals can seek healthcare in hospitals and some community health centers, access remains limited by these personal and structural challenges.

During the COVID pandemic, non-status individuals faced fewer limitations to accessing healthcare because they did not have to pay for healthcare services with the PHSUP policy. Prior to and after the removal of the PHSUP policy, individuals who had held a work permit for longer than six months, including those under the Seasonal Agricultural Workers Program (SAWP) and Live-in Caregiver Program, in theory, could obtain health coverage (Government of Ontario,

2024a). However, in practice, seeking healthcare is tied to having an active work permit, obtaining a social insurance card, and having the capacity to visit a doctor, all of which can create barriers to access (Caregivers Action Centre, 2020; Government of Canada, 2024b). Discrimination, unsafe working conditions, and a lack of clear information from employers and government institutions about healthcare rights also make it difficult for temporary migrant workers to access care (Hennebry et al., 2015; Landolt, 2022; Nakache, 2013; Villegas, 2020).

Ontario Migrant Health-Related Advocacy

Advocacy groups in Ontario have long fought for improved healthcare access for individuals with precarious immigration status. These activists, including healthcare workers, community organizers, administrative personnel, lawyers, and researchers, engage in de/bordering work to challenge the intersecting health and im/migration regulations that create unequal access to healthcare (Landolt, 2022; Villegas, 2020).

This de/bordering is particularly visible during moments of political change. For example, during the temporary PHSUP policy, activists pushed for permanent healthcare policies. Despite the temporary nature of PHSUP, advocacy continues in an effort to secure healthcare for all, regardless of immigration status. Similarly, protests against cuts to refugee healthcare under the IFH program saw healthcare professionals at the forefront (Harrison, 2018). These efforts contributed to the reversal of the cuts, marking a significant "win" for migrant health advocacy in Canada (Harrison, 2018). These mobilizations demonstrate the ongoing work of activists as they navigate both day-to-day negotiations of healthcare access for migrants and broader-scale advocacy work.

While these significant moments are key, the daily work of activists also plays a critical role in challenging health inequities and experiences of differential inclusion for individuals with precarious immigration status. I argue throughout this dissertation that these efforts, whether in broader mobilization efforts or everyday advocacy, represent acts of de/bordering. Activists serve as navigators and guides, supporting individuals with precarious immigration status in navigating the healthcare system while simultaneously challenging the broader frameworks that exclude them.

As Bloemraad et al. (2019) argue, dominant ideas, policies, and practices around who "deserves" citizenship and its associated rights, such as healthcare entitlements, have narrowed over the past fifty years. However, through their everyday work, activists challenge these narrow frameworks. By supporting individuals with precarious immigration status in accessing healthcare, activists challenge institutional constraints and the broader legal frameworks that determine eligibility. In doing so, they engage in de/bordering work that acts not only as sites of struggle, but also embodies inclusionary bordering practices, which disrupt the exclusionary aims of health and im/migration regimes (Fauser et al., 2022; Segrave, 2019; Willen & Cook, 2016). These efforts, while not always radical acts of change, still disrupt power relations and offer counter-narratives to the prevailing, dominant stories of deservingness.

Precarious immigration status plays a significant role in limiting healthcare access. It is characterized by any of the following: "The absence of permanent residence; lack of work authorization; depending on a third party for residence or employment rights; restricted or no access to public services and protections available to permanent residents (e.g. healthcare, education, workplace rights); and deportability" (Goldring, Berinstein, & Bernhard, 2009, pp. 2-3). Deportability – the pervasive threat of deportation – further prevents individuals with precarious immigration status from advocating for better living and working conditions (Basok et al., 2014; De Genova, 2002).

As Goldring and Landolt (2021) explain, people with precarious immigration status can move between status categories (e.g., student, refugee, temporary worker, asylum seeker, visitor, non-status person) like a game of chutes and ladders, where "all ladders include the possibility of a chute, thus ladders can legalize and illegalize" (Goldring & Landolt, 2021, p. 4; Goldring et al., 2009). However, as Harsha Walia, in her work *Border and Rule* (2021), writes, "No route is simple; there are few ladders and many [chutes]" (p. 227). These conditions of precarity produce "liminal qualities of temporariness, limited and mediated rights, revocability, and deportability" (Landolt & Goldring, 2019, p. 216; Menjívar, 2006).

The production of limited and mediated rights through state policies results in people with precarious immigration status facing barriers to healthcare access in Ontario (Cloos et al., 2020; Niraula et al., 2023). While Canada claims to offer universal healthcare services for all, many academics and activists have argued that this is not the case, pointing to the "problematic

gap in the universality of Canada's publicly funded health coverage" (Gagnon et al., 2021, p. 168). The Canada Health Act has a narrow definition of what it means to be a resident[7] (Gagnon et al., 2021). This narrow definition of "resident" under the Canada Health Act, combined with provincial and territorial restrictions on Medicare eligibility and immigration policies perpetuating temporary residence, sustains this gap in care. As a result, individuals with precarious immigration status are often left without healthcare coverage (Gagnon et al., 2021). Even when temporary statuses theoretically afford entitlements, many who live with precarious immigration status avoid seeking care until it becomes an emergency because of fears of being detained and deported, paying exorbitant costs, and/or facing discrimination (Asif & Kienzler, 2022; Gagnon et al., 2021).

In response, a diverse group of street-level bureaucrats or "street-level actors" work within this gap, operating as a part of an underground patchwork activist network. These individuals play an important role in mitigating barriers to healthcare access for individuals with precarious immigration status. Lipsky (1980) describes service providers as street-level bureaucrats who use their discretion to provide services to the public, stating that the "decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures effectively *become* the public policies they carry out" (Lipsky, 1980, p. xiii). Gyniadaki (2022) uses the term "street-level actors" instead of Lipsky's (1980) "street-level bureaucrats" to account for this increased diversity of individuals involved in the delivery of social services for migrants (p. 457). In this dissertation, I use the term "street-level actors" to capture the broad range of roles involved in supporting individuals with precarious immigration status in accessing healthcare, including both paid and unpaid roles, such as service providers, volunteers, community organizers, and even family members or friends/acquaintances within the community.

While not all street-level actors are activists, I focus specifically on those who engage in advocacy and mobilization efforts to improve healthcare access through de/bordering work, whether consciously political or not. By using this broader term, I aim to highlight not only the

[7]According to the Canada Health Act (1985), a resident "means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, or a visitor to the province" (p. 4). Of note, this definition does not explicitly include any reference to temporary status, however, it is possible that this may be included in the term "transient."

efforts of paid service providers but also the vital work of individuals in adjacent roles who support migrants in navigating healthcare systems.

These efforts unfold within a landscape shaped by institutional constraints that do not operate in isolation. Instead, they are embedded in broader federal and provincial immigration systems and healthcare structures. Whether working within institutions or independently, activists must navigate healthcare systems that are embedded within a complex matrix of institutions, actors, discourses, and policies. Whether attached to an institutional setting or not, they still face bureaucratic and administrative challenges, such as navigating complex eligibility criteria, advocating within fragmented and piecemeal service delivery systems, and confronting discriminatory gatekeeping practices in their efforts to secure care for individuals with precarious immigration status.

Bordering literature has highlighted a lack of research on supportive actors engaged in social service delivery (Ratzmann & Sahraoui, 2021), as well as the importance of face-to-face interactions, organizational contexts, and the macrostructural forces that produce "contingent and variable yet systemic experiences of access that in turn affect noncitizen legal status trajectories" (Landolt & Goldring, 2019, p. 215). Scholars also point to the emergence of new types of "bureaucrats" working for NGOs and in civil society (Glyniakdaki, 2022; Koca, 2021; Ratzmann & Sahraoui, 2021). Following this new literature, this dissertation focuses on paid service providers and volunteers in community organizations and civil society actors, some of whom may have the lived experience of precarious immigration status.

Literature Review

In this section, I discuss the relevant literature on migrant health advocacy, focusing on the interplay between deservingness assessments, activists' de/bordering work, and the impacts of differential inclusion within bordering contexts. Rather than conducting an in-depth literature review, I review key concepts from bordering studies, including differential inclusion, de/bordering, and deservingness. I integrate these with insights from social movement theories on stories[8] and feminist affect theories of emotion. Together, these theories help me build a conceptual framework to explore the spatiotemporal and emotional dimensions of activists'

[8] While I broadly engage Polletta's (2006) work on storytelling in the context of social movements, it is worth noting that her analysis is also grounded in cultural sociology.

work, specifically how their ideas of deservingness are shaped by the socio-political contexts in which they work, the storytelling they hear and tell, and their emotional responses to the challenges they encounter in conducting this work. This literature review synthesizes existing research on these concepts to provide a foundation for analyzing migrant health advocacy in Ontario.

Pierre Bourdieu's *Theory of Practice* (1977) provides a useful framework for examining the relationship between structural constraints and resistance within bordering spaces. His concepts of capital (resources), habitus (dispositions shaped by past experiences), and social fields (spaces where action and interactions occur) (Bourdieu, 1977) provide a helpful starting point for analyzing activists' migrant health negotiations, the structural/institutional constraints they face, and the actions they take to resist these constraints. Scholars increasingly apply this framework to social movement and bordering literature (Bauder, 2011; Côté-Boucher et al., 2014; Samuel, 2013). For Bourdieu, dominant systems govern the processes linking capital, habitus, and fields, legitimizing unequal power relations and resource distribution. His theories of practice provide a means of examining the relationship between systemic exclusion and social change (Ancelovici, 2019; Husu, 2012). I use Bourdieu's concepts as a starting point for analyzing the structural constraints and resistance actions that occur within bordering spaces, providing a conceptual foundation for examining how deservingness assessments, differential inclusion, and de/bordering efforts play out in practice.

In bordering scholarship, deservingness assessments as 'moral' decisions are contrasted with rights claims in "formal juridical discourse that presumes fundamental equality before the law" (Willen & Cook, 2016, p. 96). When used as a tool of selection and classification, conceptualizations of deservingness distinguish between migrants perceived as deserving and those who are not (Ambrosini, 2023). These distinctions are primarily constructed by socio-political discourses, laws, and policies (Carmel & Sojka, 2021). Through these discourses, laws, and policies, ideas of deservingness provide social legitimacy to entitlements (Carmel & Sojka, 2021). This legitimacy has a direct impact on access to social services, including healthcare (Carmel & Sojka, 2021). In this sense, these dominant ideas of deservingness operate as a "legal" category that demarcates belonging based on differential inclusion factors, such as migration status, coloniality, and racialization (Larios et al., 2024; Romero, 2006; Villegas, 2018).

While Willen and Cook (2016) argue that deservingness is a nuanced concept – one that is relational, context-dependent, mutable, affect-laden, and syncretic – their framing of it as the "flip-side of rights" (p. 96) creates an analytical distinction between rights-based claims and deservingness assessments. Although they do not explicitly portray these two concepts as mutually exclusive, they highlight this separation to underscore the distinct role that deservingness assessments play within migrant health contexts. While this analytical separation is useful for clarifying how deservingness assessments are made, it is crucial to recognize that, in practice, rights and moral understandings of deservingness are deeply entangled. As I elaborate in Chapter 3, actual discourse around deservingness is messier and more interconnected than Willen and Cook's (2016) framework suggests, prompting me to call for an explicitly multi-dimensional analytical approach.

This reconceptualization has been called upon by numerous scholars in bordering and migration fields, with some arguing that the term needs reconceptualization and others arguing for a new term altogether (Carmel & Sojka, 2021; Ratzmann & Sahraoui, 2021). In particular, bordering scholars argue that conceptualizations of deservingness should go beyond the binary of the "deserving" and "undeserving" (Carmel & Sojka, 2020; Ratzmann & Sahraoui, 2021, p. 437). Carmel and Sojka (2021) argue that deservingness binaries disguise "the complexity of intersecting moral economies of welfare and migration in politics and governance…articulated in intricate webs of overlapping policies, conditions, and justifications," generating complex forms of stratification and differential access to rights and inclusion for precarious status migrants (p. 648). Much like these intricate webs, deservingness, when viewed as non-binary and multi-dimensional, reveals the complex social fields in which these assessments operate. Street-level actors engaging in de/bordering work within these social fields thus contribute to this web, interpreting and constructing stories of deservingness in the process. As I will argue in Chapter 3, this storytelling process is iterative; activists, through their telling and re-telling of stories, work in complex, sometimes paradoxical ways to shape and challenge power relations. Unlike binary representations of deservingness that simplify the complex dynamics of restriction and resistance in bordering spaces, this approach better captures the multiple layers shaping deservingness evaluations involving spatial, temporal, and emotional elements.

Reviewing the broader bordering spaces where these discretionary deservingness assessments occur is also important. Scholars have increasingly described borders and bordering as processes rather than 'things' like fences or walls (Diner & Hagen, 2012). Borders and bordering are dynamic and relational processes where the bordering practices of street-level actors are shaped by bureaucratic and discretionary decisions in hospitals, workplaces, and schools (Brambilla, 2020; Newman, 2006; Paasi, 1998; Van Houtum & Van Naerssen, 2002; Van Houtum, 2020; Yuval-Davis et al., 2019). Ambrosini (2021, p. 375) describes borders as a "battleground" where street-level actors negotiate healthcare access through de/bordering strategies that challenge health inequities and mitigate experiences of differential inclusion for individuals with precarious immigration status. While institutional and structural limitations may constrain practice and limit street-level actors' flexibility to negotiate access, the internal borders regulating social service provision, such as restrictive health institution policies, cultures, and gatekeeping practices, remain mutable. These bordering practices (re/bordering and de/bordering) are dynamically shaped by the relational interactions between actors and institutions within these spaces. This includes the *work* of activists in these interactions, such as exploiting loopholes to secure healthcare (Bosniak, 2006; Landolt, 2022).

In particular, although existing bordering literature highlights the relational and dynamic aspects of borders, there is a need for interdisciplinary approaches that examine how street-level actors assess migrant deservingness, the emotional dimensions of their work, and how processes of differential inclusion unfold within bordering spaces (Bloemraad & Voss, 2020; Casas-Cortés et al., 2015; Chavez, 2013; Goldring & Landolt, 2019; Könönen, 2018; Landolt, 2022; Moffette, 2018; Ratzmann & Sahraoui, 2021; Sirriyeh, 2018; Segrave, 2019; Schweitzer, 2017). These assessments can often involve activists engaging in de/bordering practices, which can both challenge and, at times, reinforce health inequities and experiences of differential inclusion of those they support. As activists strive to create inclusion, they may unintentionally contribute to exclusion by reinforcing dominant notions of health deservingness tied to citizenship and permanent residence (Bloemraad et al., 2019; Parker & Vaughn-Williams, 2012; Villegas, 2020). The complex web of institutional policies, practices, discourses, and actors that inform activists' stories of deservingness shapes the dynamic interplay between inclusion and exclusion.

In this context, two interrelated insights emerge from current bordering literature: 1) Borders are relational and dynamic, constructed and reconstructed through discourses, policies, and practices, and 2) bordering spaces are sites of differential inclusion, both the exclusion of im/migration and health regimes and sites of struggle; de/bordering. Bordering scholars increasingly emphasize the role of street-level actors in constituting and challenging borders through their work in health and community settings, where they can contribute to reconfiguring categories of inclusion and exclusion through their de/bordering work (Ratzmann & Sahraoui, 2021).

Street-level actors are integral in the production and relationality of borders, enacting and/or disrupting bordering processes and experiences of differential inclusion through their de/bordering work (Ratzmann & Sahraoui, 2021). Restrictive bordering practices gain legitimacy through an underlying politics of deservingness, where dominant notions of deservingness, tied to permanent residence, determine eligibility for healthcare services (Bloemraad et al., 2019; Chauvin & Garcés-Mascareñas, 2014). Street-level actors' work is influenced by policies, discourses, and practices that often reinforce these ideas of deservingness (Chauvin & Garcés-Mascareñas, 2014). As De Genova (2019) argues:

> to define exactly where the imaginary line that separates…is extremely difficult… Riverbeds indeed shift from one year to another, according to water rises and floods, as does the line of a mountain ridge, depending on the quantities of snow and ice. Borders are the essential representation of themselves; they only exist viewed through this prism that we can qualify as a performance. They need to be named, loaded with meaning, for them to become a reality (p. 14).

Borders, both internal and external, determine who is included and excluded within and at the borders of nation-states. These borders are sites of restriction or "re/bordering," where inequities persist through restrictive im/migration and health policies and practices. At the same time, resistance or "de/bordering" occurs by those who challenge these boundaries (Bosniak, 2006; Casas-Cortes et al., 2014; Polletta, 2006). Both re/bordering and de/bordering processes modify borders in ways that are dynamically and relationally constituted. These practices help us understand how both structure and struggle shape migrant health advocacy, illustrating the constraints of the im/migration-health nexus while also highlighting the transformative potential of activism through de/bordering practices.

It is through the process of telling stories of deservingness in new ways – sometimes strategic and sometimes paradoxical – that people de/border and, sometimes, re/border. The actions they use and stories they draw on vary with time across different institutional and interpersonal contexts. For example, the practice of issuing newborns OHIP in Canada provides a tangible example of how differential inclusion and de/bordering operate within healthcare systems, with street-level actors using de/bordering strategies to navigate bureaucratic barriers. Families with one or both parents having precarious immigration status often face difficulties obtaining OHIP cards for their newborns (Schmidt et al., 2023). Advocacy is frequently required to navigate bureaucratic, administrative, and discretionary barriers imposed by gatekeepers enforcing restrictive citizenship and eligibility policies (Schmidt et al., 2023). A street-level actor may work within their institution to approach management and advocate for a more inclusive policy for issuing newborn OHIP cards to non-status patients based on their experiences with individual patients. From a broader perspective, a network of allies might form a newborn action working group, organize informational webinars, and collaborate with migrant health advocacy groups to hold rallies and engage in solidarity with larger structural issues that work to maintain exclusion. However, in doing so, they can also reinforce dominant discourses of deservingness by framing pregnant people or babies as especially deserving or in need of support.

This interplay between de/bordering and re/bordering practices helps us understand the emotional, spatial, and temporal dynamics of social movement work. Activists engage with, interpret, and tell different stories of deservingness, using multiple strategies depending on the specific contexts they navigate. However, these practices (of de/bordering and re/bordering) are also not mutually exclusive. They can co-occur in the same spaces, sometimes enacted by the same actors, where inclusion and exclusion are negotiated through solidarity and adherence to restrictive policies (Fauser, 2024; Rumford, 2006). This highlights the contradictory and paradoxical nature of othering, which is necessary to examine in bordering literature on discretion and deservingness (Sotkasiira & Ryynänen, 2024; Van Houtum & Van Naerssen, 2002).

Emotion and Storytelling in Social Movement Studies

Emotion is a growing area of interest in social movement studies, particularly in relation to stories (Jasper, 2011). However, while having grown, it still often overlooks the emotional and

temporal aspects of individual movement work (Polletta, 1998; Summers Effler, 2010; Van Ness & Summers Effler, 2018). In particular, there is a tendency to frame social change in isolated bursts of protest, neglecting the ongoing and iterative dimensions of activism (Polletta, 1998; Summers Effler, 2010; Van Ness & Summers Effler, 2018). My analysis extends these insights by examining how storytelling and emotion shape migrant health activism within bordering scholarship.

Polletta (2006) sees stories as fluid, relational, and dynamic processes that can be picked out of larger discourses (Polletta, 2006). At the discursive level, storytellers recount "the order of events and actions, [actors] causes and motivations, and their effects," and it is in this telling that stories play a role in reshaping bordering practice and disrupting dynamics of power (Björninen et al., 2020, p. 438).

While discourses are often used to examine sentiment and motivation for action, stories offer a deeper understanding of the personal and collective meaning behind actions (Polletta, 2002). Unlike broader discourses, which focus on societal narratives, stories allow for an in-depth examination of the individual motivations and the emotional complexities of human behaviour, offering a richer perspective on how and why people act (Polletta, 2006; Tilly, 2002). Discourses, by contrast, shape the broader systems of meaning that influence how actors experience, tell, and understand these stories (Björninen et al., 2020). Stories then can foster or diverge from dominant discourses (McCall et al., 2019).

Polletta (2006) distinguishes between "familiar" and "unfamiliar" stories. Familiar stories (upholding and adhering to dominant discourses) align with established narratives of deservingness tied to citizenship or permanent residence, thus shaping identities and social relations by sustaining existing power structures and emphasizing cultural narratives that reinforce boundaries such as "us/them" and "you/me" (Polletta, 2006). Boundaries – whether individuals (e.g. me and you) or collective (e.g. us and them) – are used to produce identities, and the structuring of social relations, and power (Tilly, 2002). These identities are also shaped by relationships, held together by stories of 'who we are', 'what we want', and 'how we do things' (Stalker & Wood, 2021).[9] Boundary construction depends on individuals or groups

[9] See also: Polletta, 2002; Tilly, 1995; 2003; 2015.

adopting and modifying shared (familiar) stories about these boundaries (Polletta, 2006; Tilly, 2002, p. 11). Tracing how these stories circulate through institutions and networks (through being drawn on and interpreted by actors) in different socio-temporal contexts reveals the circumstances under which stories gain and lose influence (Polletta, 2006; Tilly, 2002, p. 11).

Counter-discursive (what Polletta calls unfamiliar) stories can be informed by or arise out of familiar stories but are adapted, interpreted, and re-framed in ways that aim to challenge the dominant plotlines (Polletta, 2006; 2011). Activists use both types of stories (familiar and counter-discursive) as tools to resist and/or reinforce policies, laws, and practices in different moments of time through their de/bordering work, often in paradoxical and complex ways that can both create inclusion and exclusion, sometimes at the same time, such as seen in the example of newborn OHIP activism.

Importantly, in this way, stories are not always straightforward or simple; rather, they can be elusive and involve interpretative participation, with the meaning actors draw from a particular story varying based on perspective (Tilly, 2002). As Polletta (2006) notes, "Good stories are not necessarily simple ones, with unambiguous moral punch lines…Rather, narrative's power stems from its complexity, indeed, its ambiguity" (p. vii). This complexity allows activists to reframe familiar stories in new ways as de/bordering strategies. Storytelling, like other discursive forms, "is embedded in hierarchies of cultural authority that share the credibility of particular stories" (Polletta et al., 2011, p. 114). These (dominant/familiar) stories reproduce "familiar symbolic oppositions," reinforcing specific perspectives while excluding others (Polletta et al., 2011, p.14). Stories not only help make sense of and reproduce these oppositions but also offer ways to resist them, often in complex and affective ways (Polletta et al., 2011).

Emotion in Feminist Affect Theory

Emotion, affect, and stories have become increasingly central to social movement studies, largely influenced by feminist theorists who have long argued for the role of emotions as foundational to the embodiment of social relations and processes (Fotaki & Pullen, 2024; Mirchandani, 2003; Reed, 2015), including the hearing and telling of stories in bordering spaces.

While there is no single, unified theory of affect (Seigworth & Pedwell, 2023), feminist affect theories examine the socio-political effects of emotional practices, in which feelings are embedded in relations of power and social norms (Åhäll, 2018). In particular, Sara Ahmed (2010) discusses affect as being "sticky," writing that: "Affect is what sticks, or what sustains or preserves the connection between ideas, values, and objects" (p. 30). Many feminist affect scholars draw a line between affect and emotion, seeing them as distinct psychological states. Emotions refer to the sociological (or social) expression of feelings, and affect refers to the personal (biological and physical) responses to feelings (Gotron, 2009). However, many sociologists and anthropologists[10], including Ahmed (2014) have understood them as social and cultural practices, and in doing so, do not explicitly distinguish between the two terms.[11] In taking this interpretation, Ahmed (2014) blurs the lines between the affective dimensions occurring in bodies and the emotional responses that relationally shape socio-political contexts. As Ahmed (2014) states:

> Emotions are after all moving, even if they do not simply move between us. We should note that the word 'emotion' comes from the Latin, emovere, referring to 'to move, to move out'. Of course, emotions are not only about movement, they are also about attachments or about what connects us to this or that. The relationship between movement and attachment is instructive. What moves us, what makes us feel, is also that which holds us in place, or gives us a dwelling place. Hence movement does not cut the body off from the 'where' of its inhabitance, but connects bodies to other bodies: attachment takes place through movement, through being moved by the proximity of others. Movement may affect different others differently… emotions may involve 'being moved' for some precisely by fixing others as 'having' certain characteristics. The circulation of objects of emotion involves the transformation of others into objects of feeling (p. 11).

How emotions transfer within social fields and attach (stick) to different actors is important for understanding how activists' emotions are shaped by the relational contexts in

[10] Among others, Lutz and Abu-Lughod (1990) and Hochschild (1983, p. 5) argue for collapsing the distinction between affect and emotion.
[11] Social and cultural scholars generally draw a distinction between affect and emotion. See for instance: Massumi (2015); Sedgwick (2003). See Wetherall for an example of post-humanistic perspective: Wetherall (2012).

which they operate. I use both affect and emotion interchangeably in this dissertation, but I primarily use 'emotion'[12].

While social movement scholarship provides a broad foundation for understanding collective action, less attention has been paid to the specific emotional dimensions shaping activists' de/bordering work. Compassion—as a feeling—plays a central role in shaping how activists engage with stories of and about individuals with precarious immigration status and the lens through which they engage, such as one grounded in humanitarian and/or solidarity values. In this context, feelings of compassion are shaped by activists' emotional and relational attachments to those they support, and flow through the stories they tell, hear, and act on—particularly in how they assess and communicate deservingness.

For street-level actors, humanitarianism and solidarity can arise from similar feelings of compassion.[13] Yet, their affective and emotional states can result in differences in how people connect with and support each other. Humanitarianism is a concept that is not easily defined and is highly debated in sociological literature. In this dissertation, I use humanitarianism to refer to forms of care and support that are formalized, bureaucratized, and oriented towards alleviating the suffering of those considered vulnerable (Ambrosini, 2022; Cuttitta, 2018; Ticktin, 2014). Yet, these forms of care and support are often carried out through hierarchical, top-down approaches, which can reinforce unequal power dynamics between those who provide aid and those who receive it. Humanitarian action frequently takes the form of charity or "rescue," rather than collaboration among equals. In contrast, as I develop further below, solidarity rooted in compassion emphasizes equity and collective responsibility.

Solidarity is defined as "the ability of actors to recognize others and to be recognized as belonging to the same social unit," (Melucci, 1996, p. 23), and praxis involving "commitment, and work, as well as the recognition that even if we do not have the same feelings, or the same lives, or the same bodies, we do live on common ground" (Ahmed, 2014, p.189). Solidarity is often expressed through coalition-building, particularly through the formation of affective

[12] While I recognize the distinction made by scholars between affect and emotion, as outlined in the previous section, I primarily use emotion as the analytical focus of this dissertation to understand activists' experiences. However, I remain informed by affect theory particularly in relation to bodily sensations and intensities that may precede or exceed conscious emotion and action (Åhäll, 2018).

[13] The literature defines compassion in a wide array of ways, ranging from feelings of pity to solidarity (Maestri & Monforte, 2020, p. 922; Sirriyeh, 2018; Theodossopoulos, 2016).

connections and emotional bonds (Gawerc, 2021). While individuals and groups within a coalition may not have experienced the same struggles, they can still share a commitment to a common cause.

The distinction between these two frameworks—humanitarianism and solidarity—helps shape my understanding of the emotional dimensions of street-level actors' work. Humanitarian compassion often reinforces familiar narratives of vulnerability and victimhood (Willen et al., 2022), whereas solidarity-based compassion is more likely to invoke counter-discursive narratives grounded in empathy, kinship, or human rights. These differing orientations inform the stories of deservingness that resonate with activists, the ones they tell, and the de/bordering practices they enact. Thinking through compassion in this way helps illuminate how activists connect with both familiar and counter-discursive stories in their advocacy.

Activists often draw on a combination of both forms of compassion as their perspectives shift and change. They may draw on both approaches simultaneously or in specific contexts to achieve their goals within restrictive institutional settings (what I refer to as ambivalence in Chapter 5). These feelings inform the sort of stories they tell and the subsequent de/bordering practices they draw on.

Conclusion

This chapter has provided a background of migrant health advocacy and the Ontario healthcare landscape migrants and activists must navigate. It highlights several themes that will be developed further in my subsequent chapters. The first is examining in greater detail the process of activists navigating structural and institutional barriers. These barriers complicate access to healthcare for individuals with precarious immigration status and increase the emotional work placed on activists.

This chapter also reviewed literature related to bordering and some of the de/bordering work that activists take on. I examine the role of activists as navigators and guides here and throughout subsequent chapters of the dissertation to gain an in-depth understanding of activists' emotional work; their strategies, challenges, needs, and coping mechanisms.

This chapter also reviews the literature on social movements and feminist affect theory to set the stage for the conceptual framework in Chapter 3, where I elaborate on my

interdisciplinary approach to understanding activists' de/bordering work. This includes an examination of the social and institutional contexts in which activists work and the emotional dimensions of their work.

Chapter 3: Conceptual Framework

Building upon the background and literature review of migrant health activism in Chapter 2, this chapter presents the conceptual framework guiding my analysis of how activists in Ontario engage in de/bordering work to negotiate healthcare access for individuals with precarious immigration status. While I introduced the key themes of my research in Chapters 1 and 2, this chapter delves deeper into the theoretical concepts that structure my approach.

To examine the dynamics of power within bordering spaces and the role of re/bordering and de/bordering work in this process, I adopt an interdisciplinary approach, drawing from and reconceptualizing existing bordering literature, and combine it with social movement stories, and theories of affect and emotion. I argue that activists, through storytelling and emotional engagement, contribute to an iterative process of shaping non-binary, multi-dimensional, and relational understandings of deservingness. This framework allows me to explore the emotional, spatial, and temporal dimensions of migrant health activism.

I start the chapter with a brief discussion of how deservingness is framed in relation to bordering work and what is missing from this framing in the case of migrant health activism. Following this, I build an approach for examining activists' storytelling practices, emotional responses, and de/bordering practices that integrate a nuanced understanding of deservingness assessments in the context of migrant health activism.

This process of storytelling occurs across multi-dimensional and relational contexts, shaped by emotional, and spatiotemporal dimensions, and challenges dominant ideas about who deserves recognition and resources within the institutional borders of healthcare settings. These institutional borders are reinforced and resisted through stories, shaping activists' emotional responses and practices in terms of their interactions with other actors (relationality), within multiple spaces (spatiality), and at different moments in time (temporality).

The interplay between stories and emotions is key to understanding activists' de/bordering work, specifically in relation to how power is constructed and challenged within bordering spaces. The stories that activists tell can be understood as a mode through which power is reclaimed, and it is through this work of storytelling that activist's interface with and challenge hierarchies of power (for instance, related to coloniality, racialization, gender, legal

status, etc.). The multi-dimensional and relational (affective/emotional/spatiotemporal) dimensions of this work are important as it is through these dimensions that activists make connections with other social actors, building coalitions and solidarity at different moments in time.

Integrating stories and emotion opens new ways of understanding deservingness in relation to bordering and social movement spaces, in which non-binary deservingness offers a holistic picture of how people challenge dynamics of power and experiences of differential inclusion through their de/bordering work. It is through this lens that I approach understanding and addressing how activists' de/bordering strategies are influenced by shifting contexts, structural and institutional barriers, and emotional challenges.

Bordering and Social Processes: Deservingness, De/bordering, and Differential Inclusion

Understanding the interplay between the social processes of structure and struggle is essential to studying social movement bordering work as activists navigate shifting borders while reinforcing and resisting these regimes. By examining how activists engage with processes of differential inclusion, we can gain deeper insights into the transformative role (and constraints) of de/bordering work in reshaping these exclusionary regimes. These tensions between structure and struggle reflect the dynamic, relational processes that shape how borders are enacted and contested.

What I contribute to this scholarship (discussed in greater detail in the section that follows), is an examination of how discourses, policies, and practices of deservingness intersect with stories and the emotional, contextual dimensions of this work in shaping practice. It is important to examine stories not only for their content, but also for how they are used and evaluated within power structures, institutional norms, and social actions aimed at resisting restrictive bordering practices (Björninen et al., 2020; Polletta, 2006). This affective/emotional storytelling approach addresses limitations of deservingness literature, which often overlooks how activists assess deservingness in non-binary, multi-dimensional and relational ways throughout their de/bordering work in the bordering literature.

Stories and Emotion: A Multi-Dimensional, Relational, Dynamic, and Emotional Approach to Understanding Deservingness

To build my conceptual framework, I primarily draw on bordering concepts (deservingness, de/bordering, and differential inclusion) and also on Francesca Polletta's (2006) work on stories, using it as a lens to examine how stories circulate relationally among actors, institutions, and networks across contexts. I also examine how these stories relate to the emotional responses that impact activists' de/bordering work, drawing on affect theory in the process.

While social movement literature often frames stories as intentional and strategic tools (Benford & Snow, 2000), Polletta (2006) emphasizes that they are also fluid, dynamic, relational, and shaped through discourse. Stories of deservingness, in particular, are not always deliberately crafted by activists; rather, they often take shape through interactions with various actors, institutions, and contexts, though they can be used strategically in particular moments. Stories help us understand this structure/struggle debate in bordering spaces in new ways by examining the role of storytelling and emotion in challenging power through activists' de/bordering work. In doing so, stories both reflect and shape discourses that influence bordering practices, affecting how people are dynamically included and excluded through processes of differential inclusion, related to their mobility and social entitlements, such as healthcare.

However, social movement theories alone do not offer a complete framework for analyzing the contextual and emotional dimensions of de/bordering work, in part because emotion has been bracketed or minimized in social movement scholarship, in an effort to shift away from social psychological interpretations of emotions in movements (Goodwin, Jasper, & Polletta, 2000; Goodwin & Jasper, 2006). Yet understanding how activists challenge borders and negotiate healthcare access requires a deeper engagement with the emotional dimensions of their work. Therefore, I draw on feminist affect theories, (discussed in Chapter 2) to offer an interdisciplinary perspective. In particular, I engage Sara Ahmed's (2014) *The Cultural Politics of Emotion* to examine how stories of deservingness move through bordering spaces, shaped by a range of emotional contexts.

As mentioned, like Ahmed, I understand affect as part of what emotions do (i.e. how they shape experience and social interactions), and as a way to examine how individuals move and negotiate relationships across diverse contexts (Schmitz & Ahmed, 2014). I draw on affect and

emotion in two primary ways in this dissertation. The first is to understand how activists manage the emotional distress that emerges in their work through coalitions and fostering solidarity. This is explored in detail in Chapter 8. Second, I analyze how stories of deservingness shape street-level actors' de/bordering work. I focus in Chapter 5 on how feelings of compassion (specifically, humanitarianism and solidarity) are internalized by participants and mobilized to construct these stories.

Concepts of compassion, humanitarianism, and solidarity inform my understanding of activists' emotions, the stories that resonate with them, the stories they tell, and the de/bordering practices they carry out. Framing these emotional dimensions through the concept of compassion provides a lens to explore how activists make sense of and respond to familiar and counter-discursive stories and emotional tensions that emerge when they value equity and solidaristic approaches but must adopt a needs-based humanitarian approach in specific situations. Within humanitarian discourses, activists' feelings of compassion and emotional responses to their work reinforce familiar narratives of vulnerability and victimhood (Willen et al., 2022). In contrast, solidarity-based discourses are often based on and reinforce counter-discursive narratives, often of human rights, empathy, and/or kinship. A non-binary, multi-dimensional understanding of deservingness highlights the messiness of how these discourses intertwine, as activists at times draw on familiar narratives, at other times on counter-discursive ones, and often on a combination of both (ambivalence), depending on context and the strategic aims being pursued.

Storytelling becomes central to understanding how emotions circulate within and beyond social movement spaces. Narratives operate relationally. They link power, socio-political processes, and practical action. Storytelling, affect, and emotion help us understand the reproduction of dominant arrangements of privilege and power in institutions, policies, and practice, but also the "dynamics by which newly legitimated stories produce new modes of action and new terrains of contention" (Polletta, 2006, p. 7). These elements of affective storytelling shape and challenge dominant norms and, through emotional resonance, foster empathy in traditional deliberations (Polletta, 2006). Gould (2009) argues that the "*movement* in social movements gestures toward the realm of affect; bodily intensities; emotions, feelings, and passions" (p. 3) and as such, the emotional dimensions of this work are vital to explore.

Stories also contribute to the construction of compassionate discourse by fostering emotional resonance between individuals who may or may not share similar experiences. They can bring people closer together or push them apart, creating solidarity or distance. As Sharon Navarro (2003) writes, "Stories bind individuals to each other" (p. 138). The telling of counter-discursive stories or stories that are familiar yet elicit empathy (such as drawing on deservingness frames of migrant contribution or vulnerability) can produce an "affective economy" (Ahmed, 2004, p. 119) of emotions and narratives that move people closer to, rather than create distance from, the issues being advocated for (such as health inequities and challenging experiences of differential inclusion). Emotions intricately bind with the relations of power produced through stories, shaping the surfaces of individual and collective bodies and delineating their boundaries through interactions with objects and 'others' (Ahmed, 2014, as cited in Yuval-Davis, 2011, pp. 177-178). Thus, what moves people from the "balconies to the barricades" (Snow & Soule, 2010, p.133) is often, as Ahmed (2014) puts it, a feeling of closeness to or distance from a subject. This sense of "we" reflects a solidarity rooted in affective or emotional attachments and helps individuals feel part of a group or collective.

Challenging Power Relations Through Affective/Emotional Storytelling

Connecting these stories of deservingness to one's social context and emotional experiences allows me to understand, both conceptually and practically, how activists navigate bordering spaces, interacting with various stories of deservingness that shape power relations and negotiate healthcare access within the constraints of dominant discourse, policies, and practices. Conceptually, the ways that activists interact with stories can mean various things, including how they interpret a story – sometimes in ways that modify its message (somewhat like a broken telephone). In this modification of messages and telling stories through activists' de/bordering work, they engage with relations of power. Activists reproduce and resist stories of deservingness through their de/bordering work, individually and collectively.

Interpretations of stories of deservingness can be understood in terms of Bourdieu's (1977) concept of habitus – the "embodied dispositions," internalized ways of thinking, feeling, and acting, acquired by individuals according to the social fields and historical contexts in which they operate. However, unlike fixed ideas and rigid frameworks, these interpretations are mutable and dynamic. Just as habitus can evolve in response to changing social contexts and new

experiences, the ways activists draw on and mobilize notions of deservingness are continuously shaped by activists' encounters with diverse spatiotemporal and emotional contexts. Activists may draw on familiar frameworks as a cognitive shortcut to challenge health inequities, but inadvertently reflect and reinforce these same inequities. However, they also have the potential to disrupt and reframe existing power relations. In this way, deservingness becomes an iterative, constantly shifting process through spatiotemporal and emotional dynamics. Just as a person may choose a book based on genres they have enjoyed in the past, activists may draw on their emotional experiences shaped by their habitus to interpret and engage with stories of deservingness. These interpretations, however, can shift as activists encounter new settings or networks that challenge or refine their understanding of who is deserving. In this process, deservingness is constantly negotiated and reshaped, making it a non-binary, multi-dimensional and relational process for activists engaging in this de/bordering work.

By conceptualizing stories of deservingness in this expansive way, we can understand how both aspects – structure/struggle and re-bordering/de/bordering – can coexist simultaneously in bordering spaces. This messiness, dynamism, and complexity are central to this non-binary, multi-dimensional reconceptualization, particularly for analyzing the familiar, counter-discursive, and ambivalent stories of deservingness told by activists. As Hester Baer (2016) explains:

> Ambivalence…can help to make visible the way that conventional categories (of identity, aesthetics, society, politics) are being dismantled and reassembled today, while these conventions simultaneously continue to operate in ways that are fraught. In this context, ambivalence might encompass the complicated, messy, and awkward, might entail the occupation of indeterminacy and non-binary thought, might forge a path for modes of refusal not legible within conventional ways of doing politics (p. 4).

The unique position of migrant health activists, navigating both the structures working to uphold power and the struggles that challenge them, reveals new possibilities for bordering scholarship: to untether deservingness from familiar, dominant narratives. By seeing how activists contribute to and engage with both, we can understand how they disrupt the traditional constructions of these familiar stories, offering alternative stories that challenge health inequities and differential inclusion. Polletta (2006) argues that stories told in this counter-discursive way can foster emotional responses like empathy, even among those who have not experienced the

events described, thus creating solidarity. Stories can hold seemingly opposing viewpoints in "productive tension," allowing storytellers to convey and listeners to interpret meaning in various ways (Polletta, 2006). In this way, stories are a powerful rhetorical tool for questioning existing power distributions and advancing social justice, coalition-building, and solidarity (Polletta, 2006, p. 175).

For example, a non-binary, multi-dimensional, and relational approach to deservingness allows us to understand the nuances and tensions inherent in deservingness debates around migrant health activism, such as the conflict between humanitarianism and self-sufficiency, as highlighted by Welfens (2023):

> In order to be seen as deserving of protection – by law or societal standards – refugees have to demonstrate that they are at risk in their countries of origin or first countries of refuge, yet willing and able to 'overcome' their vulnerability to become law-abiding, self-sufficient and culturally malleable future members of their host societies (p. 1104).

This tension between vulnerability and contribution exposes the limitations of the binary framework of deservingness, which fails to capture the complexity of migrant experiences and advocacy to negotiate healthcare access.

This reconceptualized view of deservingness is needed because otherwise we miss the nuance in de/bordering work and how street-level actors challenge but may also be complicit in the very power relations they aim to challenge. This approach can better capture and explain tensions in de/bordering work, such as those posed by Welfens (2023). It recognizes that deservingness is a dynamic process, continuously re-defined through interactions with various stories told by social actors and found in institutions and policies.

Current binary conceptions of deservingness create a false dichotomy of deserving/undeserving, framing gatekeeping efforts as either complicit with or resisting power dynamics. I argue that reality is far more complex and nuanced than a simple binary permits. Activists carry out their work by drawing on multiple, and often contradictory, versions of both familiar and counter-discursive narratives.

This false dichotomy is evident, for example, in the process of Humanitarian and Compassionate (H&C) applications for permanent residence in Canada, where applicants and those supporting applicants must demonstrate their vulnerability and 'value' as members of Canadian society. Being deemed 'too self-sufficient' risks being viewed as not needing assistance while being 'too vulnerable' raises concerns about the perceived costs to Canadian society – socially or economically. Im/migration laws and policies follow a familiar narrative that those seeking asylum and allies must navigate to be recognized as deserving of care and protection. Activists often walk the fine line of leveraging these normative discourses of belonging, highlighting migrants' contributions and their vulnerability. As Ambrosini and Artero (2023) argue, doing so risks reproducing hierarchies of deservingness, which can exacerbate health inequities and experiences of differential inclusion of those not considered "vulnerable" enough to be deemed "deserving" of care.

However, activists navigate these normative discourses and structural constraints using strategies that draw on familiar and counter-discursive stories. These stories sometimes form ambivalent and paradoxical narratives of deservingness, adapting familiar stories of deservingness and sometimes crafting new stories that portray migrants as both vulnerable and resilient, thriving and contributing. Thus, they challenge and disrupt normative assumptions about deservingness and belonging.

One common activists strategy is to frame non-status people as both vulnerable and contributing workers, thereby reinforcing their legitimacy. However, this can also create tension by positioning some migrants as contributing and thus "deserving" (often at the expense of others) while still recognizing their vulnerability. As Robin, a social worker in the shelter system, says:

> If you are going to say that we need workers here, and we need people here, we need bodies to keep this country moving, then give people status. There's too much stigma around what it is to be a newcomer or without status. And there's [not] enough understanding of the depth of this issue and like the transnational and global issues that affect people on the ground, at every level in policymaking. I don't think [people] know the stories or care to learn them.

The example Robin discusses—of the value of migrant labour to countries, alongside global systems of exclusion that perpetuate its exploitation—illustrates the tension between

contribution and vulnerability. Bordering practices facilitate the management of capital and labour, yet these labour markets also operate outside of the boundaries of regulation, with a supply of precarious and temporary labour (Segrave, 2019). Because of this, migration policies produce a labour market that is "effectively defined by the nation-state…[with] few formal rights" (Segrave, 2019, p. 196). Migrants contribute economically through their labour, yet they face historical, structural, and institutional exclusions and there are also "internal bordering practices that run counter to the dominant nation-state commitment and performance of exclusion" (Segrave, 2019, p.197). Recognizing these nuances in the process of differential inclusion, including the ways that activists engage in contextual and emotional de/bordering work, is a powerful tool to frame deservingness in comprehensive and inclusive ways. By leveraging tensions between vulnerability and contribution, or vulnerability and agency, for example, activists can position individuals as deserving in ways that challenge the dominant binary concept of deservingness.

Conclusion

The conceptual framework presented in this chapter provides a non-binary, multi-dimensional, and relational lens through which to examine how activists in Ontario engage in de/bordering work to negotiate healthcare access for migrants with precarious immigration status. This framework integrates theories of deservingness, de/bordering, and differential inclusion with storytelling practices, offering a comprehensive approach to understanding how activists challenge structural constraints and power dynamics in health-bordering spaces.

By framing deservingness as non-binary, multi-dimensional, and relational, this framework allows us to see how activists reshape migrant health deservingness narratives in response to their interactions with various contexts and emotional experiences. In doing so, activists reframe deservingness by mobilizing familiar and counter-discursive narratives, drawing on frameworks of vulnerability, resilience, contribution, agency, and so on, in multiple ways to disrupt rigid, binary notions of who is deemed worthy of care and protection. The emotional labour involved in this work builds solidarity across contexts and shapes how activists challenge the structural and institutional inequities faced by those they support.

Ultimately, this approach contributes to a nuanced understanding of migrant health activism by including the influence of spatiotemporal contexts (the spaces activists work across time) and emotional dimensions of de/bordering work. In doing so, I demonstrate in the analysis chapters how activists engage in an iterative process of telling stories of deservingness to push forward their efforts in challenging, disrupting, and reshaping relations of power and restrictive bordering policies and practices.

I use this approach to show the messiness, paradoxes, and shifting re/bordering and de/bordering practices contributing to the dynamics of differential inclusion. The stories activists tell—and the feelings of compassion that inform them—are shaped by broader sentiments of humanitarian and solidarity that underpin their moral, emotional, and socio-political relations. These orientations shape how activists frame deservingness, devise creative strategies, and foster relationships. Yet, this emotional work is not without consequence: it requires sustained effort and can produce significant distress.

This iterative process of enacting deservingness involves constant work that can be emotionally taxing. The various stories of deservingness activists creatively engage with, and the feelings of compassion (and values of humanitarianism or solidarity) attached to these, shape activists de/bordering work, the stories they tell, creative strategizing they do, and relationships they build. However, the process does not take place without activists facing distress (discussed in detail in Chapter 8).

Chapter 4: Methodological Approach

During the first year of my PhD, I became involved in migrant health and justice advocacy, attending network meetings, webinars, and rallies. This work deepened my personal and political connection to the issues and shaped my research engagement, enhancing my understanding of the advocacy landscape and informing my research interests. As a researcher, my involvement in migrant health advocacy throughout my PhD has shaped my perspective on justice and equity issues, informing my positionality in conducting this research.

In this chapter, I outline my methodological approach to examine the emotional de/bordering work of Ontario migrant health activists. I begin by outlining my methodology and ethical considerations, followed by the specific research methods and analytical approach.

Methodology

The methodological choices made in this dissertation are informed by a sociological critical theory perspective that examines discourse, language, and meaning-making, focusing on how power relations are reproduced and resisted within health and im/migration regimes. This approach allowed me to focus on how power, inequities, and social justice shape migrant health activism and the negotiation of healthcare access for migrants facing systemic barriers.

Bischoping and Gazso (2016) define discourses as the "web of meanings, ideas, interactions and practices that are expressed or represented in texts (spoken and written language, gesture and visual imagery)" (p. 129). These discourses circulate through institutional settings and often contain contradictions and paradoxes (Bischoping & Gazso, 2016, p. 129). Stories of deservingness draw on broader discourses, shaping how activists understand and interpret their work in ways that can be similarly conflicting and paradoxical (Polletta, 2006). This messiness—the ambivalence and paradoxes that reflect a non-binary version of deservingness—is important to my analysis because it helps me better understand how activists actually engage in their work on a day-by-day basis.

These stories of deservingness help us understand the continuous re/construction of social interactions and relations through language and familiar/counter-discursive plotlines (Bischoping & Gazso, 2016; Polletta, 2006). Holstein and Gubrium (1995) write that individuals are not passive recipients of discourses. Instead, their agency is shaped by their engagement with and

experiences of intersecting discourses (Bischoping & Gazso, 2016, p. 236). Similarly, Polletta (2006) notes that stories are "bracketed in a flow of discourse; they call the listener's attention to the reality they reveal" (p. 89), but that these stories are also "interpreted by their audience" (p. 9). Thus, both discourses and the stories they contain are subject to interpretation. The stories and discourses that individuals encounter can also evoke emotional responses, which can provoke action and shape their involvement in activism in ways deeply influenced by how they interpret these narratives.

Critical discourse analysis (CDA) focuses on the study of shared concerns, power, and social inequality (Bischoping & Gazso, 2016). CDA draws from various social theorists, including Althusser, Foucault, Gramsci, and Bourdieu to examine questions of power and inequality (Bischoping & Gazso, 2016). As noted, I specifically use Bourdieu's (1977) ideas of structure and struggle, including habitus, as an analytic lens to understand how social relations and bordering practices take shape. Habitus helps us to understand how ideologies and discourses shape individual behaviours (Bourdieu, 1977). It can be understood as how material conditions produce ways of being in the world (Bourdieu, 1977). While common sense ideologies can become naturalized or automatized (Fairclough, 2009), exposure to specific stories—such as witnessing injustice, for instance—can challenge this ideology and motivate people to respond in diverse ways to counter these hegemonic ideologies. For example, migrant health activists may engage in de/bordering solidarity to challenge normalized, dominant discourses. These responses are shaped by diverse emotional experiences and contexts. Importantly, my approach to analyzing the emotional and contextual dimensions of migrant health activism is informed by a feminist-informed CDA framework, which considers the intersectional and relational construction and contestation of power along racialized, gendered, socioeconomic, and immigration status-based lines.

CDA also offers a means of analyzing how institutional discourse shaped public understandings of health and equity (Smith, 2007). "Discourses in health care are transmitted orally, textually, or symbolically…within organizations and institutions, policy documents are one way in which discourses are codified and transmitted textually" (Evans-Agnew et al., 2016, p. 4). Fairclough (1992) describes this as intertextuality, the way institutional texts draw on and reproduce other documents, circulating dominant discourses that reflect the perspectives of those

in power (Fairclough, 2009). Through intertextuality, "some discourses become dominant, often allowing those with the most power to shape the discussion" (Evans-Agnew et al., 2016, p. 139). These documents may reinforce certain "familiar stories" of deservingness, constraining how street-level actors can advocate within institutional settings.

Discourses and stories, in the context of migrant health advocacy, can be used to influence social practices in ways that de/border and/or re/border. De/bordering can involve overt actions (e.g., speaking out or protesting), or more subtle ones (e.g., selectively ignoring restrictive policies) (Phillips, Lawrence, & Hardy, 2004). In Chapters 5–7, I examine how activists use both forms to navigate exclusion.

Bischoping and Gazso (2016) suggest that discourse does not fit together neatly like a jigsaw puzzle, where each piece has a fixed place. Instead, they suggest envisioning discourse as akin to Lego blocks: flexible, reconfigurable, and open to various arrangements. This view allows researchers to construct meaning through interpretation, but also demands methodological rigour and reflexivity (Bischoping & Gazso, 2016). While CDA has been critiqued for lacking consistency in its application, it remains a valuable method when applied with attention to power, interpretation, and positioning.

Like Lego blocks, CDA is a method that assembles, challenges, and reconfigures meaning. With my analysis of deservingness, emotions, stories, and activist practice, I use CDA to trace how power relations, shaped by racialization, colonial logics, and anti-im/migrant sentiment, shape migrants' experiences of differential inclusion and health inequities (Bischoping & Gazso, 2016; Foucault, 1978). As Bishoping and Gaszo (2016) write, CDA holds "emancipatory potential" (p. 304) making it a useful tool for understanding the emotional de/bordering work of migrant health activists.

Methods

I used qualitative data collection methods, including in-depth, semi-structured interviews with activists and the gathering of Ontario health and government documents. These materials formed the basis of my data set used to conduct a thematic and discourse analysis of both the interview transcripts and collected secondary documents.

Interviews were conducted via Zoom or phone due to COVID-19 constraints. Prior to each interview, participants completed an informed consent form, in accordance with Tri-Council ethics guidelines.[14]

Given the intensity of the pandemic period, I was mindful of participants' time and emotional bandwidth. Interview lengths varied considerably because of this—ranging from 15 minutes to over an hour—depending on participants' availability and capacity.

Recruitment and Ethical Considerations

I initially recruited participants through personal and professional networks, beginning with family and friends involved in healthcare provision or migrant health advocacy. My first interview was arranged through these connections. I then used snowball sampling, asking participants to refer others within their networks who might be willing to participate. I received several referrals this way, with interviewees contacting people on my behalf or putting me directly in touch with them.

I have been, and remain, involved in key migrant health advocacy networks in Ontario – networks that focus on the rights of migrant women and non-status individuals. I contacted these networks via email listservs and identified several people willing to be interviewed. I also encountered some challenges recruiting participants through these networks (described below), which resulted in challenges reaching network members for recruitment.

Using snowball sampling within specific networks may have narrowed the scope of my sample. Because my initial interviews were recruited through personal networks, this may have shaped subsequent participant selection. The sample may be biased toward individuals engaged in specific forms of advocacy linked to my own connections, potentially excluding those outside my core network or peripheral to its extended ties. To mitigate this, I also sought participants outside my immediate networks. However, my community work has been primarily centered in urban institutions, rather than rural areas. As a result, a significant analysis of rural migrant health advocacy is not included in this dissertation and remains an area for future research.

[14] Throughout the interview data collection phase of my research, I followed the guidelines of the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans: https://ethics.gc.ca/eng/policy-politique_tcps2-eptc2_2022.html

While I aimed to include a range of activists from different institutional and advocacy roles, my networks were more connected to health provider-led advocacy rather than community migrant-led advocacy. This may have introduced sampling bias in terms of whose perspectives were represented.

In addition to completing interviews, I collected secondary data—institutional and governmental health documents. I primarily used the open-access databases of the Ontario Hospital Association (OHA) and the Alliance for Healthier Communities (AOCHC). I also collected documents from community organizations, the Government of Ontario, and the Ministry of Ontario Health websites, all of which helped to inform my analysis of the interview data.

One of the major challenges I faced during my recruitment process was establishing trust with individuals and communities I hoped to work with. I have not experienced having precarious immigration status, and while I did go to nursing school several years ago, I am no longer involved in the practical side of providing medical care to people. In many ways, I took on the role of the researcher by "turning back" or practicing the reflexivity that G.H. Mead (1962) describes as bending back on oneself, understanding that the experiences upon which this process is based must also be understood as socially constructed (Steier, 1991). In undertaking this work, I had to account for the power dynamics that shape research relationships, including my own position as a white settler academic.[15]

I consulted primarily with one migrant health advocacy network while developing my research goals, dissemination strategies, and interview guide. Early in the process, one member of this network expressed concerns about the focus on activists' strategies and requested clarification on which strategies I would include in my research. This person was hesitant to

[15] A note on self-reflection: D'Arcangelis (2018) writes that "self-reflexivity can help the subject to look beyond its self towards the collective aspects of our subjectivities and in doing so also look at the structural power relationships "in which we are enmeshed and interpellated" (p. 340). Thus, for D'Arcangelis, self-reflexivity is most valuable when it is approached as a window into structural oppression and privilege itself and not only a window into the power of researchers as individuals. Wood (2017) argues that community-based research conducted by inexperienced researchers can often do more harm than good, writing that "the need to reflect carefully on the intricacies of participation, power, privilege, and relationships is paramount in [research, in particular, community based research] before entering the field and requires constant monitoring" (p. f3). While I would not claim to be doing community based research, nevertheless, these questions of how to not do harm, and about power, privilege, and relationships were and continue to be very important to me throughout my research process.

circulate my call for participants until I presented at a network meeting. After the presentation and incorporating feedback into my recruitment materials, the network member still chose not to share my call more broadly. This advocacy network is primarily composed of providers; however, working with members of the precarious status community, they are (rightly so) protective of the community that they provide care to, and as such, wanted to make sure that my research could not result in any form of harm to those living with precarious immigration status in Canada. As consulting with community allies was vital for me, I spent a lot of time working with them to figure out what was okay to include in my dissertation and what was not okay. For instance, my research looks at activists' strategies to increase access to healthcare for people with precarious immigration status. However, this dissertation avoids detailing strategies that contravene legalities because highlighting these strategies could lead to restrictions being put in place by policymakers if the strategies are revealed.

Participants were very forthcoming in describing strategies that were not always considered "legal" or were loopholes in the current system that they used to navigate and expand access. What are the potential consequences of publicly revealing strategies that individuals use, which may not be considered fully "legal" or might exploit loopholes? While these strategies can be helpful for people working with individuals with precarious immigration status to share within their networks, making these strategies visible can draw attention to the use of these loopholes. It was only in consulting with members of migrant health justice networks that I understood these concerns around wanting to preserve this "underground patchwork" of access (Vivian, Nurse, Clinic). At this point, I had already conducted a few interviews earlier in my interview process. However, after further consultation with these network members, I clarified my research study to state that strategies that contravene "legalities" would not be included in the dissertation out of an abundance of caution to ensure that the strategies and the precarious status residents that participants assist are not identified.

Interview Data Collection

I conducted 47 qualitative interviews with migrant health activists across Ontario between October 2021 and November 2022. These interviews were interspersed with early rounds of analysis to help identify emergent themes. To ensure my interview guide reflected concerns relevant to frontline advocacy, I consulted a network leader involved in migrant health work.

Their feedback helped refine my questions, particularly around deservingness and institutional gatekeeping. Figure 2 outlines the broad geographical makeup of participants.

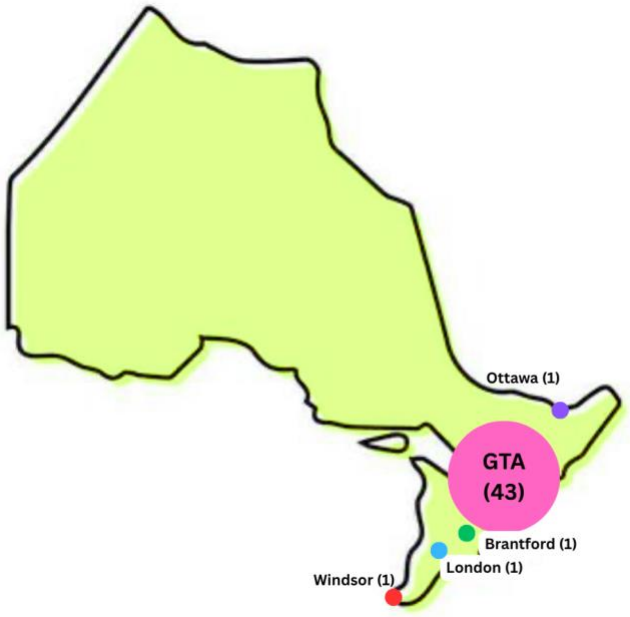

Figure 2: Geographic Distribution of Participants in Ontario

Participants worked in a range of institutional and organizational settings and held diverse roles within these settings (see Table 1 below). Participants were not directly asked about their experiences of having precarious immigration status, given the sensitive and potentially distressing nature of this topic. However, 13% voluntarily disclosed past experiences of immigration precarity. This figure may underrepresent the actual number, as it is based solely on self-disclosure.

The sample includes individuals working both within and adjacent to formal healthcare institutions, including those involved in community settings or with lived experience of precarious immigration status. This flexible recruitment (where I had activists "self-identify" as activists) allowed me to examine how de/bordering strategies unfold across institutional and community spaces. In my recruitment materials, I included the following: "Are you someone who has experience helping people with precarious immigration status access health care in Ontario? As a part of my research, I'm interviewing service providers and community workers who have experience assisting precarious status persons with accessing health care in Ontario." I

also stated that my research aimed “to understand how health care activists help individuals with precarious immigration status to navigate Ontario’s health care system.” By using the term activists, I may have unintentionally caused some potential participants to question whether they ‘fit’ this category. This may have led some individuals to self-exclude, which could potentially limit the breadth of responses of my sample.

Table 1 provides an overview of participants' primary workplace, their role, and their involvement in advocacy, whether day-to-day, broader mobilizing, or a mix of both. This offers context about the diversity of roles among those engaged in this work, and how this patchwork of access is made up of a range of actors in diverse roles and institutional contexts. Some roles, such as doctors, nurses, social workers, and administrative workers, appear across multiple institutional settings, including hospitals, CHCs, and clinics. Individuals in these settings accounted for approximately 70% of my sample, while others—such as organizers, dieticians, lawyers, and researchers—made up a smaller proportion and were less widely distributed across institutional settings. In these varied contexts, participants were positioned to advocate in ways that were both fostered and constrained by their role and institutional environment. For instance, participants working in CHCs often had more flexibility and institutional support to engage in advocacy than those based in hospitals. This matters because people could occupy the same role but experience different limitations or opportunities depending on their institutional context. This is discussed in greater detail in the analysis Chapters 5 through 8.

Table 1: Role and Advocacy Involvement by Workplace/Network

Workplace/Network	Role	# of People in Role	% of People in Role (out of Total)	# Involved in Broader Advocacy
Hospital	Doctors	8	17.0%	7
	Social Workers	1	2.1%	0
	Administrative Workers	2	4.3%	0
CHC	Doctors	3	6.4%	1
	Social Workers	2	4.3%	2
	Community Health Worker	1	2.1%	1
	Administrative Workers	2	4.3%	1
	Dietician	1	2.1%	0
	Midwife	1	2.1%	0
	Management	1	2.1%	0
Clinic	Doctors	2	4.3%	2
	Nurses	6	12.7%	4
	Midwives	2	4.3%	2
	Administrative Workers	1	2.1%	0
	Speech Language Pathologist	1	2.1%	1
	Management	1	2.1%	0
Migrant Rights Network	Activist Organizers	3	6.4%	3
	Administrative Workers	2	4.3%	2
Community Legal Clinic	Lawyers	2	4.3%	1
	Social Workers	1	2.1%	1
Government	Dietician	1	2.1%	1
	Researchers	1	2.1%	1
Religious Institution	Administrative Workers	1	2.1%	1
Community Organization	Administrative Workers	1	2.1%	0
		47	99.9%	31

Document Data Collection

In addition to interviews, I collected secondary data from health institutions and governmental health documents from 2012[16] to 2022 to contextualize the interview findings. These included materials from the Ontario Hospital Association (OHA), the Alliance for Healthier Communities (AOCHC), the Government of Ontario, and the Ministry of Health, as well as documents from community organizations involved in health access advocacy.

I used the following selection criteria to find relevant documents: those published between 2012 and 2022 pertaining to an Ontario health institution or governmental policy relating to health, and including one of the following key terms: “undocumented,” "uninsured,” “precarious status,” “non-resident,” and/or “non-status.”

I selected 54 documents that fell into the following categories: policy documents, policy briefs, educational resources (e.g., PowerPoints, healthcare service guides for advocating, resources for uninsured patients, infographics), blog posts, community/research reports, and advocacy letters.

Collecting these documents allowed me to understand the different regulatory and institutional landscapes within which activists worked and to inform my understanding of the multi-level healthcare discourse at the federal (Canada Health Act), provincial (Ontario health regulatory bodies, such as the OHA and AOCHC) and local institutional levels (administrative policies in hospitals and CHCs).

While I reference these documents throughout the dissertation, I did not perform a systematic analysis since many collected documents did not discuss issues related to being uninsured or having precarious immigration status.

Data Analysis

To analyze both interviews and secondary documents, I used a combination of thematic analysis (Clarke et al., 2015) and discourse analysis (Braun & Clarke, 2006). These methods allowed me

[16] The start date of 2012 was chosen for this dissertation because it allowed me to look at the cuts and subsequent reintroduction of the Interim Federal Health (IFH) coverage in 2016 for those with refugee status in Canada.

to examine both recurring patterns in participants' narratives and the institutional discourses shaping those narratives.

For the thematic analysis, I first transcribed the interviews and then conducted a close listen to refine my understanding and generate an initial set of codes using MAXQDA software. This coding process helped me trace how activists articulated concepts such as deservingness, emotional distress, and their de/bordering strategies in their everyday terms.

By discourse analysis, I mean that I examined how language is used to construct meaning and produce ideologies in both institutional and everyday settings (Bischoping & Gazso, 2016). I applied this approach to both the interview data and secondary documents, enabling me to analyze how structural and institutional narratives shape and are reshaped by activists' emotional experiences. In particular, I was interested in how dominant discourses around deservingness and access to care are reinforced and resisted in these data.

By combining these methods, I was able to explore both the individual meaning-making processes of activists and the broader institutional frameworks in which they are embedded, including how their emotional contexts inform their experiences and practices.

In the sections that follow, I first clarify my theoretical approach to discourse analysis, highlighting how I conceptualize and apply key analytical concepts used in the dissertation, including emotion, deservingness, and storytelling to understand migrant health activists de/bordering work. Following this conceptual discussion, I outline the specific strategies used to conduct thematic and discourse analysis of interview data. Finally, I detail my method for analyzing the institutional and governmental health documents, before outlining some methodological limitations.

Discourse and Thematic Analysis Strategy

I began the thematic analysis by identifying patterns that emerged from the interviews. The codes I constructed included themes such as, learning, advocacy pivoting, moral distress, institutional culture/regulations, helping, education, strategies, relationships, and deserving. From these codes, I created subcodes that informed my discourse analysis.

The interviews were analyzed in three stages: I first conducted the thematic analysis; second, I cross-tabulated participants' institutional context, networks, relationships, and

discourse relating to affect/emotion (specifically distress and deservingness); and third, I measured advocacy involvement by assessing whether participants' engagement was limited to their workplace or if extended to broader advocacy. I also analyzed how long participants had been involved in advocacy in relation to their institutional roles, discussed in detail below.

To conduct this analysis, I first coded the interview transcripts to identify themes by comparing codes across different transcript sections. Next, I cross-tabulated the codes to examine areas of overlap. For instance, I cross-referenced participants' institutional contexts with the broader advocacy networks they were part of. I used the crosstab feature in MAXQDA to conduct this part of the analysis.

I also established words relating to distress and deservingness from my coded themes. I did so by first establishing a set of initial words for each set, selected by reading through coded sections that I had established as relating to each section. I had a distress and deservingness code in MAXQDA, but I had relevant sub-codes for deservingness, such as "needy," "disability," "kids," "older people," and "gender." For distress words, I searched through interview transcript sections coded for distress and created an initial list of words, including but not limited to *frustrated, difficult,* and *heartbreaking*. I had already established these sub-codes for deservingness, so I went through these codes to develop an initial list of words, such as *need, empathy, human, and vulnerable.*

Once I had initial word lists, I used the autocode feature in MAXQDA, applying a lemmatized search to capture word variants (e.g., "frustrate," "frustrating," and "frustrated"). I identified additional variations of related words by examining the context around distress and deservingness terms. I expanded the list further by reviewing context manually, reading each interview in full to ensure that relevant language around distress and deservingness was not missed.

To assess participants' distress, I conducted a systematic content analysis of distress-related language in all 47 interview transcripts. I compiled a lexicon of over 50 iterations of distress-related terms, including emotionally charged expressions commonly used by participants (such as "my hands are tied", "depressing," and "heartbreaking") (Appendix A). Using MAXQDA, I searched each transcript for these terms and recorded their frequencies. For each

transcript, I divided the total number of distress-related words by the interviewee word count,[17] then multiplied by 100 to calculate the percentage. Doing so allowed me to get the word frequency as a percentage of each whole transcript so that frequencies could be compared across transcripts.

However, because emotions are inherently subjective, and interviews varied in length, this method has limitations. Additionally, participants' language varied depending on factors such as their relationship with the researcher and the level of trust, which can affect how emotions are expressed and captured.

To measure advocacy involvement, I considered the extent to which participants were engaged and involved in activist activities at the individual and broader systemic level. To do this analysis, I searched the interviews, finding that participants fell into one of two categories of advocacy: 1) individual advocacy inside their institution (directly benefiting activists' patients/clients or themselves living with precarious status) or 2) broader advocacy, in which they were engaged in advocacy both within and outside of their respective institution.[18]

I then compared participants' advocacy involvement with their institutional affiliations and workplace roles to understand how institutional position influenced the flexibility to engage in advocacy. Participants' work location also helps contextualize their capacity for building relationships, accessing networks, and participating in resource mobilization – core concepts in social movement theory. This context further informed my analysis of stories of deservingness as they circulated within and beyond institutional settings.

I explored several analytic approaches over the course of this study. Some early-stage analyses that did not ultimately inform the core findings are included in Appendix B to document the process and rationale for their exclusion.

[17] This word count measurement was done in MAXQDA. Only language used by interviewee (and not interviewer) was included in this measurement.
[18] Notably, there were no people who were engaged only in advocacy outside of their institution, so this was not included as a category for analysis.

Document Analysis Strategy

This analysis allowed me to examine the policies and practices that perpetuate inequitable power relations and health disparities in Ontario. It also highlighted how citizenship-based notions of health deservingness create a boundary, reinforcing restrictive bordering practices and familiar narratives that shape access to healthcare services for individuals with precarious immigration status. While Ontario healthcare institutions follow provincially mandated rules, there is some variation in their policies about being uninsured or living with precarious immigration status, including the costs associated with healthcare treatments/procedures, payment collection, and professional guidelines and training for encountering those without insurance. Considering these health and government documents was helpful for analyzing the relationships and interplay between local and national modalities informing healthcare access. For instance, CHCs included client services guidelines on their websites stating that they serve marginalized communities, including people without health cards and/or uninsured/non-insured clients.

By contrast, terminology of uninsured, or similar such descriptors, and documentation pertaining to issues faced by those who are uninsured/have precarious immigration status were not found in great frequency in my initial search of governmental and hospital health documents. The limited knowledge of precarious status and access to healthcare in Canada may have contributed to the lack of publicly available documents (Hudson et al., 2016). This created difficulties in the collection of documents. However, I aimed to collect this secondary literature to understand the public circulation of health policies and documents. As such, I opted only to collect open-access documents. Using this method allowed me to gather sufficient documents to inform my analysis.

I use these documents throughout the dissertation to inform my analysis and provide context to the interviews. These documents were particularly valuable for understanding the bureaucratic barriers within institutions and participants' discretionary practices in the absence of formal policies and procedures. This is explored further in Chapter 6, which examines the role of formal and informal institutions in shaping de/bordering strategies. Participant interviews corroborated these findings, as participants described how bureaucratic and administrative constraints shaped their experiences. They also highlighted how informal strategies—often based on praxis building, social learning, and network/coalition-building—were essential for

navigating these constraints, reinforcing the strategic de/bordering efforts to circumvent the lack of formal policies and procedures.

This secondary data helped situate participants' narratives within the broader discursive and institutional environment shaping healthcare access. It also allowed me to contextualize how activists' accounts of navigating healthcare exclusions aligned with, resisted, or reinterpreted dominant institutional framings of eligibility and deservingness.

Conclusion

The use of thematic and critical discourse analysis methods provided valuable insight into how migrant health activists negotiate healthcare access for people with precarious immigration status through their de/bordering work. The health documents analyzed from the OHA, AOCHC, community organizations, and government websites helped inform and contextualize the interview data. The analysis chapters that follow highlight the results of this analysis, looking at activists' storytelling and how it impacts their emotional de/bordering work (Chapter 5), their specific strategies (Chapters 6 and 7), and challenges faced (Chapter 8) while engaging in this de/bordering work.

Chapter 5: Activist Stories of Deservingness

This chapter investigates how street-level actors draw on stories of deservingness in their de/bordering work, using compassion as a lens to explore the emotional dimensions of their work. As Polletta (2006) argues, stories are "forms of discourse [and] vehicles of ideology" that shape how people draw meaning from discourse when they are "absorbed or transported by a story" (Polletta, 2006, p. 112). Stories, discourse, and affect/emotion are deeply interconnected as relational meaning-making practices that emerge through situational contexts, often mobilized to move audiences emotionally (Ahmed, 2014; De Fina & Georgakopoulou, 2020; McAvoy, 2014).

In this chapter, I draw on the concept of compassion and the value systems through which it is expressed (specifically humanitarianism and solidarity) to understand how activists creatively mobilize stories of deservingness in their de/bordering practice. These value systems shape ethical orientations toward care and inclusion, influencing activists' perceptions of who deserves access to care. I analyze interviews and health documents to examine how these relational and emotional dynamics shape activists' strategies for navigating structural and institutional constraints, spatiotemporal contexts, and tensions through storytelling as central to their de/bordering work.

As I outline in Chapter 3, activists engage with stories of deservingness in ways that both challenge and reinforce exclusionary systems. Stories are powerful tools for mobilizing support and creating spaces of resistance, but they also shape perceptions of who is "deserving" of care, sometimes inadvertently reproducing dominant bordering practices. This chapter builds on this argument by examining how activists negotiate these tensions across different institutional settings, interpersonal relationships, and emotional contexts.

I make three central arguments in this chapter: 1) storytelling is a key element of de/bordering practice that activists use to do their work; 2) activists' institutional context shapes which stories they can tell and how they engage in advocacy; and 3) the stories they tell have variable impacts on their practice and the types of change they are able to create.

Contrary to much of the existing literature on deservingness (discussed in Chapter 2), my analysis shows that participants did not rely on a single, fixed understanding of health

deservingness at any given time. Their interpretations shifted situationally based on emotional, interpersonal, and institutional factors, moving between humanitarian (familiar/dominant) and solidarity (countering dominant discourses) perspectives, or reflecting ambivalence. This chapter demonstrates that deservingness is relational, context-dependent, and emotionally charged, shaped through the stories activists tell and encounter as they negotiate access to healthcare.

This chapter begins by revisiting and building on the key concepts introduced in Chapter 3, deservingness, compassion, humanitarianism, solidarity, and storytelling. It then examines how participants engaged with stories of deservingness at an individual level, focusing on the relational and emotional dynamics of storytelling within their networks and institutional contexts over time and across settings. I focus particularly on how they use a range of stories (familiar, counter-discursive, ambivalent approaches) to pursue their advocacy goals across these shifting advocacy landscapes.

Compassion: Humanitarianism and Solidarity

As previously discussed, humanitarian compassion frequently emphasizes vulnerability and need, reinforcing familiar stories of deservingness. In contrast, solidarity-based compassion highlights equity, often resulting in counter-discursive narratives of deservingness. While my analysis treats compassion, humanitarianism, and solidarity as inherently political, particularly given this dissertation's context of migrant health advocacy, this position is not universally shared. Instead, the political nature of compassion remains debated with some scholars viewing it as fundamentally apolitical, while others argue explicitly for its political significance.

For instance, Arendt (1996) describes compassion as a "de-politicizing emotion" (p. 153: Artero, 2024). Many political theorists and sociologists share this apolitical view – and, as Fleischmann and Steinhilper's (2017) show, even civil society volunteers often describe their advocacy as a non-political activity (Artero, 2024). However, as Ambrosini (2024) suggests, this may stem from volunteers' efforts to strategically frame collective actions as rational and legitimate, rather than overtly political. They seek to avoid being labeled as "change agents," "political dissenters," or other emotionally charged terms that opponents of the movement use to delegitimize it. This also connects to the view that emotions are "temporary and fragile" (Ambrosini, 2024; Hamann & Karakayali, 2016; Kleres, 2018), and therefore, not seen as politically legitimate or robust. Activists who use storytelling to mobilize face similar critiques,

with their narratives often seen as driven more by emotion than reason—marked by affective identification that overrides logic and evidence (Polletta, 2006, p. 82).

From this perspective, there is a fear that storytelling focused on emotional mobilization can risk leading to divisive movements and less effective decision-making (Polletta, 2006). Ambrosini (2024) notes, however, that compassion is not in direct opposition to political commitments to justice and rights and can be seen as a "political virtue" (p. 522). Polletta (2006) similarly argues that storytelling can address limitations in traditional political deliberations by challenging dominant norms, fostering empathy, and including a range of emotional and affective dimensions (Polletta, 2006). As such, both Ambrosini (2024) and Polletta (2006) talk about how compassion and stories can be political (even while emotional).

While the emotional dimensions of compassion discourses, deservingness assessments, and the political implications of storytelling are important elements in activists' work, a gap remains in understanding how these dynamics specifically shape activists' de/bordering efforts. Although much attention has been given to the concept of deservingness and migrants' stories or experiences (Bönisch-Brednich et al., 2023; Chattopadhyay, 2019; Musarò & Moralli, 2019) there is arguably less research on the stories that migrant health activists tell in their day-to-day work, the emotional and contextual dynamics that shape these narratives, and how activists use storytelling as part of their creative and strategic de/bordering practices to negotiate access to care.

My research addresses these gaps by examining how discourses of compassion and stories of deservingness influence street-level actors' de/bordering work, with a focus on what activists' "do" with stories in practice and how emotional and contextual factors shape that practice. While compassion is often framed as depoliticized, activists engage with stories of deservingness shaped by humanitarian and solidarity discourses to navigate institutional constraints and advocate for healthcare for those they support. However, as I will demonstrate in this chapter, these stories of deservingness are complex; the same stories can both disrupt and reinforce existing hierarchies of inclusion and exclusion.

Institutional Context and Storytelling Constraints

Institutional settings contribute to shaping how participants as activists engage with stories of deservingness. The policies, cultures, and dominant discourse within these institutions influence how participants advocate for healthcare access, including how they frame their narratives and how they emotionally respond to them. As Polletta (2006) suggests, stories do not emerge in isolation; they are embedded in broader institutional and social contexts that structure which narratives are considered legitimate, persuasive, or possible.

Institutional discourses often reinforce dominant ideas of deservingness tied to citizenship and legal status, creating challenges for activists advocating for expanded healthcare. Encounters with these discourses, whether through formal policies, unspoken workplace norms, or bureaucratic obstacles, can limit activists' capacity to challenge dominant narratives. At times, these constraints force activists to adopt familiar humanitarian framings of deservingness, even when they might prefer solidarity-based approaches.

Participants' Roles and Institutional Constraints

In terms of institutional setting, participants in hospital and government-funded clinics often face strict policy regulations on who can receive care. Without clear institutional guidelines for treating uninsured patients, hospital-based participants report having to rely on individual case-by-case advocacy rather than systemic change efforts. Some engage in "workarounds" and informal negotiations to secure care for those they support, but these efforts can inadvertently reinforce narratives of exceptional deservingness (e.g., prioritizing children, pregnant women, or visibly suffering individuals).

Many participants working in hospitals reported feeling limited in their capacity to advocate within their workplace due to a lack of clear policies or guidelines on providing care to individuals with precarious immigration status or uninsured individuals, as indicated in the OHA documents I reviewed. This lack of policy guidance may explain why some hospital-based participants sought advocacy opportunities outside of their institution to sustain their work amidst bureaucratic and administrative challenges. A few participants in hospitals worked at institutions with mission statements that did align with their advocacy goals. However, such cases were exceptions rather than the rule.

In contrast, participants in community-led organizations faced fewer restrictions in advocating within their institution. Those in CHCs and community organizations generally had greater freedom to engage in advocacy as part of their paid roles compared to those in hospital settings. This was supported by institutional discourses emphasizing collaborative care and advocacy, particularly in AOCHC documents However, even in CHC's, advocacy was constrained by Canada Revenue Agency (CRA) regulations, which restrict non-profits to spending only 10% of their time and resources on political activities,[19] and these activities must be non-partisan (Cheff, 2017; CRA, 2003). This restriction serves as an example of the way institutional limitations are also connected to the broader structural barriers that limit migrants' access to healthcare.

Despite these limitations, participants in CHCs and clinics generally had greater flexibility for advocacy compared to those working in hospitals. This difference is primarily attributed to the mandates of CHCs and specific clinics, which focus on serving marginalized groups, including those with precarious immigration status and uninsured individuals. However, some CHCs also face challenges, such as restrictions on providing healthcare to international students, who were often assumed to be covered under student health insurance plans.

While many hospital-based participants faced challenges in advocating within their institutions due to the lack of policies on precarious immigration status and uninsured individuals, they still continued their advocacy, leveraging loopholes when possible. These efforts helped provide immediate care, but they could inadvertently reinforce dominant narratives of exception and cause emotional distress in this process. Participants often alleviated this distress by expanding their networks, through engaging in solidarity and coalition-building, which often allowed them to learn creative ways to engage in de/bordering practices.

Altogether, a consideration of both institutional and individual stories of deservingness allows for an analysis of how participants navigate their work within and outside of institutional

[19] Examples of permitted political activities include:
- buying a newspaper advertisement to pressure the government
- organizing a march to Parliament Hill
- organizing a conference to support the charity's opinion
- hiring a communications specialist to arrange a media campaign
- using a mail campaign to urge supporters to contact the government - organizing a rally on Parliament Hill (CRA, 2003).

contexts. These relational contexts matter because they shape the social fields that activists engage with, influencing how they interact with bordering spaces, interpret stories of deservingness, and respond emotionally. These emotional responses, in turn, can shape how activists engage in de/bordering practices.

Regardless of the workplace setting, many participants extended their advocacy beyond their institutions, participating in migrant health networks and activist coalitions to push for broader systemic change. Appendix C provides an overall summary of the major de/bordering strategies activists use in their work, the impacts of this work, and challenges related to the work.

Through considering these institutional constraints, we can better understand why some participants adopt certain storytelling strategies over others (discussed in the section that follows). While activists in hospitals might depend on humanitarian (familiar) stories that align with existing policies, CHC and grassroots activists may have greater freedom to contest these prevailing (familiar) narratives through solidarity-based stories. However, these choices are not always conscious, participants de/bordering work is also shaped by the discourses and stories they encounter, the emotional weight of their work, and the constraints imposed by institutional cultures. Building on this institutional analysis, the next section examines how broader discourses of humanitarianism and solidarity shape activists' stories of deservingness and their approaches to de/bordering work.

Compassion: Humanitarianism and Solidarity

Participants draw on two primary discourses—humanitarianism and solidarity—to shape their stories of deservingness. The humanitarian discourse, which emphasizes vulnerability and moral urgency, is often mobilized to adhere to institutional discourses and can reinforce hierarchical ideas of who is considered "deserving." In contrast, solidarity discourses focus on challenging and critiquing systemic barriers through collective empowerment, which has the potential to invoke counter-narratives that disrupt dominant structures of exclusion. Notably, inequality can also be reproduced unintentionally within spaces of solidarity. Collective movements often involve both a struggle for resources and challenging forms of othering (Anthias, 2021). As Tilly (1998) argues, external inequalities can filter into collective movement dynamics and reinforce relational power dynamics within advocacy organizations (p. 78).

Humanitarianism is often used to mobilize support but can also contribute to selective inclusion. By contrast, solidarity often involves using tools such as knowledge sharing and social learning, to disrupt and transform health and im/migration systems, foster mutual equity, and reframing deservingness as a shared political struggle.

Solidarity was evident, for instance, in the organization of vaccine clinics for migrants during the COVID pandemic, where healthcare workers and migrant-led justice organizers worked collaboratively, not just delivering care to migrants, but partnering with them. This included responding to community-defined needs, such as training healthcare workers to avoid language that could create fear. For example, Anne, a doctor, who worked with migrant-led groups, spoke about working together to come up with scripts for healthcare workers to say "do you have something that has your ID? If you have OHIP that's great. If you don't, no problem," instead of asking "Can I see your OHIP [card]?" which could provoke anxiety, fear, and deter participation. Another key strategy in this solidarity work was having migrant-led groups conduct outreach directly, ensuring that community members with precarious immigration status were aware of and felt safe accessing the clinic. This strategy resulted in over 2000 people being vaccinated over the course of 4 days. So, while charity and humanitarian work can sometimes aim for similar goals to ensure access to healthcare, they often reinforce forms of exclusion through conditional inclusion. In other cases, more direct gatekeeping, such as asking for OHIP, can directly exclude or deter migrants from accessing healthcare. Solidarity, by contrast, moves beyond service provision rooted in charity or humanitarianism towards a collective effort grounded in mutual respect, equity-based support, and a shared struggle of countering dominant discourses of inclusion.

Still, importantly, at an individual and collective level, these perspectives are not fixed and change across spatiotemporal contexts, and in response to activists' emotional experiences. Through their interactions with various stories of deservingness, across these dimensions, participants "*do* things with stories. They entertain and persuade, build social bonds and break them, make sense of their worlds and, in the process, create those worlds…they occasionally do so in ways that are socially transformative, [but] much of the time, the stories that people tell discourage overt challeng[ing] of structures" (Polletta, 2006, p. 14). In this context, activists do not simply respond to these stories; they also re/shape and challenge them, often exploiting

loopholes in current policies and legal frameworks and creating spaces of resistance within existing structures.

To understand these dynamics and the tensions that arise in this work, the next section examines these three key storytelling practices: familiar, counter-discursive, and ambivalent in more detail. As shown in Appendix C, some de/bordering strategies rely on the reinforcement of familiar stories of deservingness. However, across these strategies, activists also draw on counter-discursive stories and ambivalent to challenge and complicate dominant narratives of deservingness, which can foster knowledge mobilization, praxis-building, and lead to broader inclusionary policies and practices.

First, participants engage in familiar stories of compassionate humanitarianism rooted in vulnerability and suffering as tools for advocacy within constrained institutional settings. Second, participants drew on solidarity discourses, telling stories rooted in a collective or shared political struggle. While least likely to reinforce dominant stories of deservingness, these stories risk being dismissed or may alienate audiences because they often draw on counter-discursive stories that counter dominant discourses. Third, storytelling could often bring about feelings of ambivalence, recognizing people's constraints (e.g., being vulnerable to barriers in access) and their struggle (as agentic actors). Participants draw on these paradoxical versions of deservingness to make sense of them and to help others see deservingness in new ways that foster empathy. While this relationship produces stories that seek to disrupt power dynamics, they can also inadvertently reproduce them.

(Familiar) Storytelling as a Tool for Advocacy

At times, participants draw on familiar stories, consciously or unconsciously, while engaging in their advocacy work. Familiar narratives can reinforce dominant ideas of deservingness, aligning with the institutional stories activists seek to challenge. De/bordering work can, therefore, involve treading the fine line between disruption and reinforcement of power structures, depending on factors such as the advocacy goals (immediate or long-term) and the specific spatiotemporal context (restrictive or supportive).

Navigating the tension between re/bordering and de/bordering is a key challenge in advocacy work. The stories activists hear and tell play an important role in revealing and

understanding the power dynamics involved within this tension. For instance, it is often the stories that draw on lived experiences of individuals with precarious immigration status that are the most powerful in motivating policy changes or successfully gaining access to services, despite these familiar narratives risking reinforcing existing power structures.

Hearing and telling stories of deservingness—rooted in humanitarian discourses of vulnerability and struggle—elicits emotional responses and can strongly motivate action. Participants are "moved" to act based on emotional and affective experiences, and they do so while navigating institutional and structural barriers that influence their capacity to act and the kinds of stories they tell under various circumstances. These constraints also inform the stories of deservingness they tell, and in some settings, drawing on familiar stories of deservingness can help participants negotiate access.

Some participants draw on familiar stories to secure healthcare access for those they support in the moment, despite institutional constraints. This impetus for action can result from being moved emotionally to take action. For instance, John, a doctor working in a clinic that rarely treats individuals with precarious immigration status, spoke about witnessing suffering and hearing directly from the patients he has encountered. He emphasizes how these personal connections shaped his advocacy work:

> [Advocacy] has to come from a human place… it has to come from connecting with somebody on a human level…maybe somebody that doesn't know anything about the issues, doesn't believe that some person should get healthcare in a broader way but then you're talking to someone… if you're sitting in front of somebody and hearing their story of not having access to healthcare that's so much more impactful for an individual…It's really having people's stories at the center.

John's example demonstrates that storytelling in advocacy often involves complex emotional engagements that can make political issues feel personal and human, which can, in turn, foster moral urgency and emotional resonance. However, it also exemplifies the challenges related to navigating de/bordering and re/bordering through sharing familiar stories. While such narratives can create emotional resonance, listeners can also interpret them to support dominant stories of deservingness that reinforce health inequities and experiences of differential inclusion. Given their impact, this dynamic results in key tension for participants, who must be careful

when choosing which stories to tell. This underscores how participants sometimes strategically frame stories to create the greatest impact depending on the context – whether at a large mobilization or rally versus in one-on-one advocacy settings.

Stories provide us with a context of place, time, and emotional resonance in the telling. They help both the teller and the audience make sense of events (Polletta, 2006). As Polletta (2006) suggests,

> We tell stories for many, perhaps innumerable, reasons: to entertain, to illustrate, to instruct, to envision alternatives, to comfort, to dramatize, to help us live with the contradictions that are an unavoidable feature of existence, to grasp temporality, to feel (p. 11).

Yet, even when stories generate empathy, they do not always result in structural change. Polletta (2006) emphasizes that stories help us imagine and feel things across moments in time. The same stories or slightly different iterations of stories often have to be told differently, to different actors, to make an impact. As Polletta (2006) reminds us, emotional resonance alone is not always sufficient to compel action. Although people may empathize with someone else's suffering, it does not ensure they will change their behaviour. This underscores an important nuance: to be human is to have a story, but not all stories resonate equally. Stories that emphasize particular forms of suffering or vulnerability, such as that of a child, tend to have a greater impact.

As a result, stories alone may not inspire action unless they are told in ways that help people connect with experiences that might otherwise feel distant or counter-discursive. This often requires creatively sharing stories at specific moments with particular people to generate impact. Storytelling is therefore an iterative, shifting, and dynamic process. As part of their advocacy work, participants engage in this process through the re/telling of stories of deservingness across various contexts, not only to make sense of their own emotions, but also to motivate others toward change. For instance, they sometimes relied on familiar stories of suffering and vulnerability within constrained institutional settings to secure access in individual cases, particularly when appealing to policymakers or challenging restrictive bordering practices. In doing so, activists (both as individuals and collectively), make creative and strategic choices

about which stories to tell, when, and how to frame them in order to achieve their desired advocacy goals.

The emotional dimensions of street-level actors' work require navigating complex, discretionary decisions. These decisions involve balancing compassion for those perceived as in need with the reality that they can only do so much, often necessitating the problematic process of excluding some individuals. At times, activists must justify these exclusions to themselves to manage the emotional distress accompanying these difficult decisions (discussed in detail in Chapter 8). This creates tension wherein activists are forced to set boundaries around their work. In doing so, the conflict between compassion and exclusion shapes their actions, practices, and the stories they tell. Given that stories have an evaluative component and an underlying moral (Polletta, 2006) the meanings that arise from positioning some as more deserving than others can lead to a normative conclusion and reinforce familiar narratives of deservingness. While rooted in personal assessments of deservingness, these stories connect to, influence, and are influenced by larger discourses. As a result, activists' narratives can unintentionally align with and reinforce broader discourses in media, institutions, and other actors. These discourses can reinforce institutional barriers regarding exclusions, and contribute to re/bordering within these organizations and society at large.

Perceived vulnerabilities – such as supporting a child, an older person, or a pregnant woman – played a significant role in shaping bordering strategies for some participants. As a result, selectively inclusive care might facilitate access for some while unintentionally reinforcing barriers for others. Street-level actors may not necessarily engage in deliberate re/bordering practices such as gatekeeping; however, their discretion in positioning certain individuals as more vulnerable or more deserving than others often perpetuate narratives that reinforce hierarchies of deservingness and processes of differential inclusion.

Participants discussed the structural barriers in which immigration status in Canada determines healthcare access and the difficult decisions they face about who receives care and under what circumstances. For instance, Krista, a lawyer working in a community legal clinic, referred one of her clients with precarious immigration status and a disability to Service Ontario to get an ID needed to travel to another province to attend their parent's funeral. As Krista explained:

> You almost just want to shake the person at the counter to be like, I know there's a list of people waiting, but like, can't you just use some common sense to… expedite this, for this really needy person?

Notions of exceptional deservingness – like this example by Krista talking about wanting to secure a case for this particularly "needy" person – highlight how activists' discretionary decisions are shaped by situational, institutional, and structural constraints. It also demonstrates how activists often draw and reinforce familiar narratives of deservingness rooted in vulnerability. Krista, for instance, described experiencing a rewarding feeling when providing services to migrants, "especially when they have kids." A similar sentiment was echoed by Teo, reflecting on the IFH cuts: "It's odious to think about taking healthcare away from these families with children who have fled horrible circumstances." In both cases, Krista and Teo navigate the bureaucratic limitations of healthcare systems. Yet, their moral or value systems are also engaged as they assess who deserves care in these moments. This interaction between personal ethics and structural constraints creates feelings of ambivalence. These feelings often create emotional tension and can lead to emotional distress (as discussed in Chapter 8). However, ambivalence also has a productive quality; it can motivate activists to seek resolution, sometimes by developing creative workarounds to restrictive healthcare systems (as discussed in the case of Jaya below and in more detail in Chapter 6).

Jaya, a nurse in a clinic, illustrated these institutional and bureaucratic challenges when describing the difficulties he faced negotiating care within the broader structures regulating access. Specifically, he described the obstacles they faced in securing mental health care for those he supports:

> [There are these] little tiny barriers that prevent care and how we get it. For more acute issues, we're just doing the best we can…We have our workarounds, but our workarounds are kind of silly. One of the only [organizations] that will take our clients [with mental health issues] won't do outpatient services. They'll do inpatient services for them if they get admitted into hospital.

Jaya went on to describe one of the patients with precarious immigration status who was living on the street and facing a mental health crisis, stating that in order to get him healthcare, he:

> Had to form him, which is really not a nice thing to do, the Form 1[20]… getting medications that's one of the hardest things to do…he needed injectable medication… it's like $300 a month, so these are huge barriers. The alternative is that we have to wait for him to get sicker, enough that we can form him, get the police involved to do a detention…the police just do whatever they want, they don't wait for us, they'll just do it at whatever time, so we can't really mitigate harm and be there for him, he goes to ER, and then luckily people seem to know us there and then we just beg them for an admission so we can get the ball rolling for the healthcare treatment and getting access to what's needed. You can see how it's a pretty frustrating system when you have a precarious immigration status. Things that I wanted to do earlier to improve someone's quality of life, I'm not able to do that. And I have a lot more workarounds than other people…I even have a small budget for medications, but it's just really difficult to get.

In cases where institutional and structural constraints prevent care, such as the case Jaya discusses here of obstacles to securing medication for mental health challenges (these limitations are discussed in Chapter 6), participants often used storytelling performances to support patients in presenting themselves as deserving of healthcare. Storytelling, in this sense, is not only a way of framing individual instances of deservingness but also a tool to disrupt institutional and systemic power structures by leveraging and negotiating care. As Polletta (2006) explains, narratives are "differently intelligible, useful, and authoritative" (p. 3) depending on who is telling them and the specific spatiotemporal contexts in which they are shared. For example, "when sharing your story at a loan office, you will likely express different things than you would in a church confessional or a courtroom" (p. 3). The examples from Jaya's story and Polletta's argument illustrate how power hierarchies shape assessments of deservingness and how activists engage with these stories in ways that create emotional resonance, and this can have the effects of securing access, shifting ideas, and driving action, particularly by those in positions of authority, such as healthcare providers. However, as mentioned, drawing on familiar stories of deservingness can inadvertently reinforce negative perceptions of vulnerability and

[20] Jaya described the use of Form 1 as follows: "as a physician has assessed [a person] in the community [and determined that they are] at a risk to themselves or somebody else. Or if they are not taking a certain treatment, it is reasonable to assume that they will harm themselves or that they will harm someone else and there is currently an appropriate treatment that will prevent that." While forming someone has significant consequences (such as police involvement and detention), Jaya described it as a last resort workaround to access healthcare when no formal or accessible alternatives are available. Waiting until someone is "sick enough" to be formed reflects the difficult choices activists must make while navigating a structurally constrained system.

victimization, reproducing hierarchies of deservingness where some individuals are seen as worthy while others are excluded.

To summarize, familiar stories can create tension for activists. While these stories can effectively mobilize people, evoking emotions and driving action, they often rely on dominant narratives about migrants that activists may not fully agree with or outright disagree with. As a result, using familiar stories can be a tool activists use to secure access and/or drive change and a mechanism that reinforces the very power structures activists seek to disrupt.

(Counter-Discursive) Storytelling as a Tool for Disrupting Power Structures

Participants drew on counter-discursive stories of deservingness in their de/bordering work to 1) reframe dominant narratives about deservingness, and 2) equip individuals with precarious immigration status to challenge those narratives themselves. These stories were frequently used by participants engaged in broader systemic advocacy, reflecting their emphasis on structural change. However, participants also balanced this work with timely advocacy efforts to support individuals during specific moments. This highlights how participants navigate their de/bordering work flexibly responding to shifting needs and contexts.

These counter-discursive stories received the most attention in participant interviews, often described in greater detail and with more emotional resonance than familiar or ambivalent stories. This may be because they were particularly impactful or memorable, standing out as moments of disruption and radical challenges to systemic and institutional constraints. Some participants mentioned these stories in response to questions about memorable advocacy moments. It is also possible that participants assumed I was seeking specific types of stories. While more examples of these stories are included here compared to others, this does not imply they are more important; rather, it reflects what participants chose to emphasize during our conversations.

Participants' counter-discursive stories often directly challenge dominant discourses, such as the idea that Canada has a ‘universal’ health system or is welcoming to immigrants. For example, Sage explains why Canada’s healthcare system is exclusionary and highlights systematic challenges where immigration status determines access:

> [Speaking about why the healthcare systems is exclusionary] it's because we tie so much to immigration status…The system is designed this way intentionally… the state benefits from people being in a precarious status situation because the state is not trying to give people stable status. They do not want to give them membership rights. They do not want to give them social benefits. They want to continue to extract their labour and not be responsible for their needs.

Sage's story reframes the dominant narrative of Canada as inclusionary by foregrounding the nation-state's role in systemic exploitation. Similarly, Nia, a social worker in a CHC, connects the healthcare system to broader systems of oppression:

> Our whole healthcare system is a part of dominant systems of white supremacy. This internalized belief that healthcare is a privilege that only belongs to Canadians of a certain stature and status…I've been witness to different forms of racism, anti-Black racism, people disclosing unnecessary information in front of other people, reporting/threatening to report folks to their embassy… We have to think about who is accessing care…who tends to be uninsured? It tends to be migrant workers from racialized backgrounds who were here for a chance of a better opportunity, labour workers doing jobs such as dishwashing, in the healthcare field, in the actual field in southern Ontario, helping us with our food. So, the folks that are helping us are of a specific status typically, and those are who are being impacted by these [healthcare and im/migration] laws.

Robin, another social worker and white immigrant, reflects on her own privileged access and contrasts it with those she supports, highlighting racialized disparities:

> I got citizenship very quickly, no barriers… Why are our stories so different? When I think about people here [Canada] ten, forty years later, [without] access, it's mind-boggling, so I know there's something wrong… it's racism and xenophobia

Robin's reflections emphasize the privileging of whiteness in processes of differential inclusion, and in doing so, her story counters the dominant discursive myth of a universal, inclusive healthcare system.

Another form of storytelling involved sharing knowledge and resources to support people with precarious immigration status—often led by those who had once held precarious status themselves and now occupy positions of authority or privilege (e.g., as healthcare providers)—in order to empower others to challenge dominant narratives of deservingness. For example, Julia

(who once experienced precarious immigration status and now works as a midwife) provides information to pregnant people in Facebook forums:

> I try to advocate [by giving] information…so people make informed decisions… I'm part of [these Facebook] groups…every now and then, somebody's like, "I'm pregnant; what do I do? I have no idea where to go" …And then I'm like, "Okay, well, these are your options if you have a health card, if you have a family doctor, if you don't, this is what you can do. This is how we [midwives] work…Giving people information so they know how to proceed versus just going by fear…People are like [in the Facebook forum], "I need to go to the hospital because what if the cord comes around the [baby's] head?" I'm like, "That happens very infrequently." …So, for me, it's my job to provide all that information to be like, "Listen, this is what is normal. This is what is not." …My clients are mostly Spanish speaking; they don't have a good sense of English, especially when they are in appointments, and it's hard… Midwives really try and there's translation services, but it's not always straightforward.

Julia's experience highlights how intersections of migration, gender, and racialization shape selective inclusion in processes of differential inclusion. The lack of accessible information provided to individuals with precarious immigration status when seeking healthcare, often combined with limited English and French language skills, creates significant health inequity. This inequity is reinforced by dominant discourses and familiar stories of deservingness tied to citizenship, membership, and associated bordering practices. Julia notes that providing her clients with information about the Ontario healthcare system improves their understanding and empowers them. She observed that her clients often do not receive the necessary information to help them navigate the healthcare system. By disseminating knowledge, Julia reshapes these stories and promotes health equity.

Similarly, Ellie, an administrative worker in a community organization, described how she supported a client during the COVID pandemic. She explained how front-desk hospital staff in emergency departments often act as gatekeepers, wielding discretion that can exclude migrants before they even access care. Ellie recalls one such incident:

> [So, I told them – person she was supporting] this is what it's going to happen, you have to go to the nearest hospital, and they will ask you for the OHIP. That's the first thing that they will ask all the time; you will say I don't have OHIP, however, I need to see a doctor urgently. I have this emergency. So, they will do an intake, probably a social worker from the hospital will

> approach you, ask you for all your information, they won't share anything, and they won't charge because it's by the Ministry of Health that they won't charge you." I gave this information to them, then they called me and were like, "Hey, this is happening at the front desk of the [hospital] emergency room. The lady is being so rude with me, she's saying racist things…saying that because of me, and because I don't speak English, I'm messing up the system and the Government of Canada is tired of all these people this and that.

Ellie described how she intervened:

> I was like, "please put her on the phone". It's something that we advocate for [situations like this], and to be listening to this, [I] was like, "Wow, I can't believe that somebody who's in the healthcare system is saying this to people!" My [client was] trying, [they weren't] able to speak very well in English, but they were trying to get care…The client put me on speaker, and [the front desk worker] was saying really bad things. She [didn't] know that I was listening to her… I just [let her talk until she stopped, then jumped in], "Hey, I'm calling from XX… I listened to what you're saying to them, and I'm going to report [this] because it's not acceptable. [My client has an] emergency situation and you're saying this to them"… [The client after this] managed to receive the help.

Ellie's intervention demonstrates the importance of migrant self-advocacy. Knowing one's rights and having the resources and knowledge to challenge the restrictive healthcare system prior to healthcare encounters can provide individuals with the tools to advocate for access. At the same time, Ellie's example also highlights how sometimes challenging exclusionary practices also require support and extra pressure from others to ensure that people get access. As she says:

> I try always to encourage…educate people about how the system works… explain to them what going to happen. For example, [when clients get a requisition from the doctor] I always explain to them, you have to go to this place…this is the address… [which] floor, unit, and office [they] have to go. [Tell them you are there for an] ultrasound, bloodwork, whatever. The first thing they will ask you is the OHIP, but you can say I don't have OHIP; however, this is my paperwork. Here is a letter: [I'm a] non-insured person, that's it. This is a sanctuary city, and they are not authorized to request you more information about the status.

Ellie's account illustrates that while information and preparation are vital, they are often insufficient in the face of deeply entrenched racism and discrimination. As she shows, resources and knowledge of rights are essential aspects of de/bordering work, but the role of relationships and solidarity are also vital tools in challenging exclusionary health and im/migration systems.

Ellie's experience, like others discussed in this section, reflects how counter-discursive storytelling can disrupt and transform systemic inequities, even as these efforts remain shaped by broader structures of power and exclusion (Scuzzarello & Moroşanu, 2023).

Ambivalence in Storytelling: Disrupting and Reproducing Power

Polletta (2006) argues that the most "effective" stories capture the complexity and contradictions inherent in human experiences. Participants often told stories that combined complex, at times, paradoxical ideas while engaging in their work. A powerful story often reflects this simultaneity and duality of the human condition—seeing someone as both vulnerable and a rational actor, for instance (Polletta, 2006). The challenge in advocacy storytelling is capturing these dualities in ways that resonate with the people it aims to reach.

In participants' engagement with, creation of, and re/shaping of stories of deservingness through their re/telling, ambivalence (emotional tension of holding conflicting stories) can also occur. As Polletta (2006) argues, recognizing oneself in others' stories is not necessary for empathy, particularly when stories evoke complex or paradoxical emotions. Engaging with these tensions enables individuals to grapple with the multi-dimensional and sometimes conflicting aspects of these narratives. Polletta draws on Jane Murphy's (1993) work to show this complexity, in which Murphy provides an example of the capacity to empathize with women who killed their abusers, even if we do not directly identify with this particular experience. These women describe relationships where possessiveness is initially seen as love and early acts of violence are tolerated and normalized (Murphy, 1993; Polletta, 2006). Although these situations may be far removed from many individuals' personal experiences, Murphy (1993) speaks about coming to empathize with the women she spoke to, not because she immediately identified with their stories, but because the stories themselves are emotionally complex, expressing a deep tension and contradiction (Polletta, 2006). One woman described the painful experience of realizing she wanted to live while sliding down her refrigerator door during an incident of being assaulted, and another stated that her husband destroyed her *and* she never stopped loving him (Murphy, 1993; Polletta, 2006). This kind of semantic dissonance—where ideas, emotions, or words are juxtaposed in ways that are not typically combined—creates powerful emotional resonance (Murphy, 1993; Polletta, 2006). In the messiness of these contradictions, the intertwining of seemingly opposite ideas and the emotional complexity of the human experience

are captured in ways that resonate, moving people to act. Such complex stories can produce multiple meanings, often producing visceral reactions (Polletta, 2006). When connections between these seemingly disparate ideas are made, they can evoke an emotional response that draws the listener towards the storyteller. This emotional resonance may be what ultimately motivates action. It is not the immediate recognition of yourself in the suffering of others that leads to empathy, but rather the complex emotional engagement with a story that creates solidarity and drives action.

For example, framing non-status migrants at the intersection of vulnerability (e.g. deportability) – and agency (e.g., as community members or self-advocates) can add nuance to debates about deservingness. This reframing highlights how activists use storytelling in their de/bordering work in various ways, depending on relational and spatiotemporal contexts, such as their audience or how their advocacy evolves.

A recent example of this reframing can be illustrated by an organizer without status who stated in a Toronto Star article, "I am afraid, but I am not afraid," adding in a news press conference, "Everyone deserves to live as a human being." (CBC, 2025). This seemingly contradictory statement, displaying both vulnerability and agency – captures the complexity of how activism, speaking out, and storytelling can reframe deservingness. Such reframing of deservingness, as the organizer puts forward here, enables a rethinking of identity[21] constructions of migrants through a process whereby activists (both those with precarious immigration status and their supporters) engage in the iterative act of sharing stories of deservingness that are both about resilience and vulnerability. For many participants, this iterative process of sharing stories also involves the work of knowledge building and praxis within coalitions. Through this process, activists learn from one another, empower each other, and share knowledge as tools to support their emotional de/bordering work.

One participant, Nara, who had lived with precarious immigration status on and off for 15 years but is now a permanent resident and works at a community organization, discussed how vital this knowledge sharing was for her, and to learn about the available support.

[21] While outside of the scope of this dissertation, the relationship between stories and identities has also been prominent in social movement literature (Polletta, 2006; Tilly, 2002).

> I was still in and out of hospitals at some points during that time [during their graduate degree on an international study permit]. That also impacted my work because I really needed to coordinate with people because I needed support. There were people telling me you owe half a billion dollars… Let me talk to friends, you reach out to friends, you reach out to your professors, you reach out to people you know in the community…this is how I learned about different networks of doctors who are working within the system... And this is what you do because I need to figure out and get the information myself first. To survive.

Nara's reflection exemplifies how ambivalence can occur in storytelling. She describes the challenges of managing her health and the financial burden of hospitalization while emphasizing the necessity of seeking support. Her statement about getting information to survive can be seen as an act of resilience. Beyond this, the positioning of her story connects structure and struggle, challenging dominant discourses that frame people as either entirely "helpless" or purely "resilient" actors.

With ambivalence, along with emotional tension, can also come productive aspects, sparking change, prompting reflection, learning, and dynamic understandings. As such, the stories produced from this ambivalence can challenge and disrupt power relations by retelling stories in complex and paradoxical ways, balancing narratives of deservingness shaped by humanitarian and solidarity discourses of compassion. By embracing these paradoxes, activists retell stories across various contexts in emotionally resonant ways, thereby complicating familiar narratives of deservingness.

Conclusion: Reconceptualizing Deservingness and Healthcare Access

Storytelling plays an important role in participants' advocacy. Participants draw on familiar stories of deservingness to mobilize support within restrictive institutional environments. They also face moral and ethical dilemmas daily, as they often need to make discretionary assessments about whom to deem "deserving" of healthcare (Maestri & Monforte, 2020). These assessments of deservingness, especially those that foreground humanitarianism and vulnerability, can reinforce re/bordering when engaging in selective inclusion. Second, participants used solidarity discourses highlighting collective struggles, offering alternative perspectives on deservingness, though these narratives may face dismissal or alienation from audiences. Lastly, through ambivalent stories, they acknowledge the vulnerability and agency of those they support. While this can challenge existing power dynamics, it also risks reproducing them. Together, these

storytelling approaches deepen understanding of advocacy dynamics and the complexities of power relations.

Building on these insights, these modes of storytelling contribute to the iterative process of participants telling and, sometimes, reshaping stories of deservingness. However, in this process of reshaping, participants can also end up re/bordering, reinforcing familiar narratives of deservingness and dominant discourses upholding relations of power.

Importantly, participants' stories of deservingness shift through interactions with institutions, networks, and other actors. This reflects the iterative nature of deservingness, reinforcing and restricting activists' de/bordering work and, in the process, disrupting and, at times, upholding bordering practices and hierarchies of power, contributing to experiences of differential inclusion in this way. Participants also sometimes hold paradoxical views of deservingness, in which they can (at times) strategically and creatively draw on different narratives depending on the advocacy context. In this way, participants interact with stories of deservingness in ways that dynamically shape and constitute how deservingness is conceived across various affective/emotional and spatiotemporal contexts.

The ways these stories are translated into action—used in practice to reconceptualize deservingness and negotiate access—are the focus of Chapters 6 and 7. Chapter 6 examines the creative strategies activists use to navigate difficult institutional contexts, while Chapter 7 explores the emotional and relational work involved in building the networks through which care is secured.

Chapter 6: Activist Strategies and Healthcare Access for Migrants with Precarious Immigration Status in Ontario

As explored in the previous chapter, activists engage with stories of deservingness in complex ways, both reinforcing and resisting familiar stories. These stories do not just shape activists' emotional experiences; they also inform their practical strategies for supporting migrants to navigate healthcare access. The chapter examines in greater detail how activists translate stories into action, specifically examining the "informal" de/bordering strategies they use to negotiate institutional and structural constraints as part of an underground patchwork of activists. By informal, I refer to practices that are not codified in law or policy, or formally institutionalized, but instead operate in ad-hoc and relational ways, for example, when someone reaches out for help to negotiate access and a favour is granted based on personal connections. In doing so, this chapter examines the quiet, hidden, informal work that activists take on in the absence of formal laws, policies, and protections for migrants with precarious immigration status in relation to their healthcare access. Some of this work is ad-hoc, assembled in response to immediate needs and shaped by less systemic or consistent processes. However, much of it is more systematically informal, as activists often share contacts and resources, developing recurring practices that, while not formally institutionalized, offer ongoing coordination and continuity.

In this chapter, I examine how activists engage with stories of deservingness to navigate im/migration and health systems and negotiate healthcare access for individuals with precarious immigration status, engaging with processes of differential inclusion, namely how the inclusionary de/bordering of activists disrupts and challenges exclusionary healthcare systems.[22] It addresses the following research questions: How do activists use informal strategies to de/border and how do they navigate structural and institutional constraints while conducting this emotional work? Specifically, I analyze the quiet emotional work activists take on to support migrants with precarious immigration status in accessing healthcare – a key aspect of substantive citizenship – through formal and informal channels. I argue that while activists' reliance on informal means (such as ad-hoc strategies and relationship-building work) can risk reproducing

[22] The specific challenges that individuals with precarious immigration status face in experiencing differential inclusion, in part, stem from the process of illegalization, through which laws and policies render migrants "illegal" (De Genova, 2002). This process works to manage migration and enforce processes of differential inclusion (Casas-Cortes et al., 2015). Individuals with precarious immigration status experience distinct forms of differential inclusion which limit their access to healthcare services. Street-level actors advocate within these broader structural constraints, often using informal and ad-hoc supports to negotiate healthcare access.

hierarchies of deservingness by privileging familiar narratives, it remains a vital strategy for securing care and mitigating the effects of differential inclusion. This is especially true in the absence of formal healthcare policies and procedures for individuals with precarious immigration status.

To ground this discussion, this chapter first explores the literature on differential inclusion and discretion in street-level advocacy. Following this, I provide an analysis of the institutional contexts (hospitals, CHCs, clinics, etc.) in which participants work. Next, I examine how activists' inclusionary de/bordering strategies contribute to the dynamic processes of differential inclusion, particularly focusing on activists' strategic use of deservingness stories to negotiate care. I highlight the diverse approaches activists take to address the needs of individuals with precarious immigration status, shaped by their varying experiences of differential inclusion. This chapter examines strategies for negotiating healthcare for four key groups of immigration categories: 1) individuals with study permits, 2) temporary migrant workers (specifically those in the Seasonal Agricultural Workers Program (SAWP), 3) refugees (government assisted, privately sponsored, and refugee claimants) and 4) non-status migrants.[23] Finally, the chapter reflects on the ethical considerations involved in reporting these strategies and the precautions taken when recounting participants' narratives.

Differential Inclusion, Discretion and Deservingness in Street-Level Advocacy

While institutions and governments grant some formal entitlements to healthcare, these entitlements are often inadequate, restrictive, or inaccessible. As a result, migrants and activists must secure access through informal negotiations (Brodkin, 2011; Perna, 2021; Ratzmann, 2022). Informal networks play an important role when formal policies limit access. Institutional cultures, policies, and guidelines are shaped by structural forces that reinforce dominant discourses of deservingness tied to citizenship and permanent residency, creating spaces of discretion in practice by street-level actors. These structural and institutional constraints are discussed later in this chapter and in Chapter 7. This discretion affects migrants' experiences of differential inclusion in healthcare (Perna, 2021). As Segrave (2019) argues, these underground patchwork networks undermine exclusionary efforts by nation-states. Specifically, when the state

[23] Although it is not a formal "state" category like international students, migrants in the SAWP, or refugees and refugee claimants, it is discussed here as a category because it has been treated as such in popular discourse.

fails to provide protection to migrants, these networks play an important role in filling this gap by providing support, sharing resources, and access to information (Segrave, 2019).

However, an important paradox in the differential inclusion literature concerns the "politics of humanitarian deservingness" (Goldring & Landolt, 2021, p. 16). As discussed in Chapter 5, humanitarian-based compassion, tied to vulnerability and exception, often reinforces familiar stories of deservingness and creates a hierarchy of worth in social service provision, where need, citizenship, and contribution often determine perceived worthiness. As Ticktin (2011) puts it, in these contexts, people are viewed as "not quite deserving of rights, but in need of help" (p. 157). These narratives shape activist work: in informal network contexts and broader movements, humanitarian discourses provoke emotional responses and compel action. Yet, by framing people as vulnerable, activists encounter a tension between vulnerability and socioeconomic performance (Chauvin & Garcés-Mascareñas, 2014).

In engaging in this informal work, activists draw on humanitarian frames of deservingness to secure healthcare access under constrained conditions, often drawing on familiar stories of deservingness in the process. This reveals the tension between reinforcing dominant narratives of deservingness in advocacy work and the pragmatic need to create pathways to care. While these strategies may not directly challenge systemic barriers, they bridge care gaps, especially when formal policies are insufficient or absent. By critically examining humanitarian deservingness in relation to street-level actors' de/bordering work, I examine how activists draw on familiar stories of vulnerability to navigate exclusion experienced by those they support. However, while effective in some contexts, these informal strategies drawing on vulnerability can reinforce the systemic exclusions that activists seek to challenge.

Activists use these informal, ad-hoc strategies within broader systemic and institutional constraints and develop their de/bordering strategies through social learning (accumulation of knowledge and understanding through experiences and relationships) and praxis-building (specifically, activist practice informed by their experiences, reflections, and interactions) (Bandura, 1969; Landolt, 2022; Ross, 2017). These processes lead to creative approaches to negotiate healthcare access for individuals with precarious immigration status. As I explore in

Chapter 5, these strategies are shaped by stories of deservingness, which influence activists' emotional and affective responses and subsequently, how they de/border.

Formal and Informal Access to Healthcare

In Ontario, activists and individuals with precarious immigration status have developed informal and ad-hoc strategies—often through relationships, networks, and coalitions—to engage in de/bordering work and secure healthcare access, stepping in where formal agreements and partnerships are absent (Berinstein et al., 2007; Campbell et al., 2014; Magalhaes et al., 2010). While some formal partnerships exist between hospitals, CHCs, and midwifery clinics, these agreements fall short of addressing the needs of those with precarious immigration status in an affordable, specific, consistent and accessible way.

Participants leverage informal strategies in two main ways: 1) ad-hoc network negotiations, which ensure day-to-day healthcare access (discussed in this chapter), and 2) coalition building, which involves long-term and broader advocacy related to health inequity, mentorship, and training (discussed in Chapter 7). In what follows, I provide a brief overview of Ontario's healthcare landscape in terms of migrants' access and entitlements, then explore how activists navigate immigration and health systems to contribute to inclusionary de/bordering.

Institutional Constraints on Advocacy in Ontario's Healthcare System

One significant barrier in Ontario's healthcare system is the inconsistent cost of services, which varies not only by immigration status but also by the institution providing the service. These "state-defined legal status categories establish configurations of rights for people occupying these categories" (Goldring & Landolt, 2013, p. 3) and healthcare eligibility and access are often determined by such categorizations, shaped not only by formal laws and policies, but also by gatekeepers' informal bordering practices, depending on their interpretations of these state classifications.

For example, individuals can be charged different rates at different hospitals, with distinctions being made arbitrarily between "uninsured" and "non-resident" patients (London Health Sciences Centre, 2025; Queensway Carleton Hospital, 2025; William Osler Health Centre, 2025). As Appendix D indicates, an emergency visit at Queensway Carleton Hospital costs $302 for uninsured patients but $930 for Non-residents (Queensway Carleton Hospital,

2023). The lack of standardized rates and hospital discretion can lead to overcharging, especially for non-status individuals, who are often misclassified as visitors or non-residents (who also live with precarious immigration status, but fees are higher for those misclassified, as such) (CBC, 2020; City of Toronto, 2013).[24]

These inconsistencies often compel activists to step in and advocate for equitable, accessible treatment, filling gaps left by formal nation-state laws and policies. However, the ways they go about deciding who to care for and under which circumstances are also shaped by their interpretations of the stories of deservingness they hear and tell and by how they make sense of these stories within institutional contexts. This meaning-making often includes an emotional dimension that influences the specific actions street-level actors take when deciding whether to provide care to a person seeking treatment. It may also depend on factors like their relationship to the person involved, and their guiding principles, such as the commitments they bring from their broader advocacy work into their paid work. As Theo reflected on the emotional and moral complexities of this work:

> There's a profound societal question around doing work for which you are not financially compensated. There's your own relationship with money…there's that person in front of you who needs the services - but you won't get paid for it. And also, how well they know them… is this a patient you've had for quite some time, who's lost the ability to be able to pay, or is the individual a faceless person?

These interpretive and emotional dimensions of advocacy are shaped by broader institutional and structural constraints, such as restrictive im/migration and health policies. But participants also navigate these constraints, often negotiating directly with other actors, institutions, or networks. This included reaching out to hospital finance departments to advocate for reduced fees, and using compassion-driven arguments to challenge providers' decisions about healthcare access. Such de/bordering strategies disrupt these exclusionary regimes, as participants contribute to inclusionary bordering practices.

More formalized healthcare agreements, such as partnerships between hospitals and community health centres (CHCs), enable individuals with precarious immigration status to

[24] In collecting data on hospital billing rates, I found that many Ontario hospitals had increased their rates for Non-residents or uninsured patients as of 2023, compared to pre-COVID.

access care in a more structured and consistent way (though still informal), thereby reducing barriers to healthcare access. For instance, midwifery services in Ontario are funded through the Ministry of Health and Long-Term Care, which allows people without insurance to access prenatal care, free of charge (Association of Midwives, 2025). However, these formal agreements are piecemeal and not universally available.

These "formal" partnerships, while valuable, can also lack transparency. For example, a voluntary agreement between the Toronto Central Local Health Integration Network (LHIN) and the Health Network for Uninsured Clients, which existed from 2012 to 2019 , aimed to standardize patient billing and registration for people with precarious immigration status between CHCs working with hospitals (City of Toronto, 2013). However, these partnerships have since lapsed and remain recognized only informally. The lack of sustained formal partnerships and agreements is partly due to inconsistent provincial funding from the federal government for CHCs and clinics, and hospitals in Ontario. Uninsured funding is limited and fluctuates year to year, making it difficult for healthcare institutions to establish long-term, stable policies for providing care to individuals with precarious immigration status (Ministry of Health, 2024).

Informal De/bordering

In what follows, I draw on participant interviews to better understand how the intersections between im/migration and health systems shape migrants' access to care, activists' feelings towards those they support, the stories activists hear and tell, and their de/bordering work. Table 2 summarizes how activists use multiple de/bordering strategies to challenge health inequities and mitigate differential access to healthcare – access that contributes to processes of differential inclusion.

Table 2: Activist Strategies to Challenge Healthcare Inequities Faced by People with Precarious Immigration Status, by Immigration Status Category

Precarious Immigration Status Category	**De/bordering Strategies**
International Student	Reaching out to finance departments Collecting informational resources (such as finding out where to access health services and the criteria for accessing these services) and material resources (such as collecting clothing and household supplies) Building relationships to negotiate healthcare fees
Migrants in the Seasonal Agricultural Workers Program (SAWP)	Mobile health buses travel to farms where people work to offer care (calling farmers to promote mobile clinics sand telling them to let workers know about in-person and virtual clinics) Going to places where people shop, such as malls and grocery stores Planning events and meetups
Refugees – Government Assisted Refugees, Privately Sponsored Refugees, and Refugee Claimants	Developing a working knowledge of specific providers who will provide care Developing agreements with hospitals for OHIP rates Education and outreach regarding IFH policies
Non-Status	Applying for compassionate funds at hospitals Negotiating with pharmacies to get supplies for their clinic that could be provided to non-status clients Hospital workers drawing on networks and agreements with CHCs to refer patients as soon as they identify a need for more comprehensive care than their institution can provide Calling on friends for favours in emergencies

Table 2 demonstrates the ongoing and strategic work activists engage in to secure access to healthcare for those they support. This continuous work evolves as activists learn how to best navigate the "chutes and ladders" of immigration status categories, working across restrictive im/migration and health systems that impose varying forms of exclusion through state-defined classifications.

International Students

International students with study permits are eligible for UHIP or CIHIP through their educational institutions (HNUC, 2024). Navigating healthcare access for these individuals involves interacting with both healthcare and institutional insurance providers, creating additional barriers.

Elizabeth, who worked as an organizer and was previously an international student, pointed out that despite having insurance, some of her "classmates had to pay an extra charge, even though they had a student plan." When incorrect charges were billed to those with

precarious immigration status, participants spoke about contacting hospital finance departments to correct or reduce these charges.

Nara shared her experience with a large hospital bill and inadequate insurance coverage. After being hospitalized in a province outside of Ontario for a chronic condition, she faced a $500,000 bill. Her UHIP insurance refused to cover any part of the cost. After being contacted multiple times by a collection agency, Nara moved to Ontario and was hospitalized again shortly after for mental health reasons. The insurance again refused coverage, citing that it was because it "was a self-inflicted injury." Fortunately, Nara had become involved in advocacy work and had established connections with activists working with the healthcare system. These connections helped cover some of the costs. However, she still faced significant challenges in accessing affordable care. As Nara explains:

> I [got access to healthcare through], I want to say under the table or through the ways that would help me to access the services, even though I would not be eligible or, I wouldn't normally have access to, and I will have access because I know so and so…through the network of friends. So, in that way, I had access to services whenever I needed to.

In this example, Nara builds relationships, engaging in social learning to navigate affordable care in the absence of formal entitlements. This reflects how participants use multiple de/bordering strategies to negotiate access, including leveraging relationships, but also seeking resources and other forms of support indirectly related to health, including housing rights. Mei, who works as a college instructor part-time, noted that during the COVID pandemic:

> I had quite a few international students [in my class] who were not aware of what they were supposed to do, nobody was telling them about their insurance. And the insurance doesn't cover many things as well… [they] were asking me about their rights around housing…they weren't sure when the landlord can kick them out, what are their rights, because at [colleges] there is no place designated specifically to take on international students in terms of settlement services. Colleges are taking money from international students, but there's a huge need [for settlement services]. I personally went to collect a few items like blankets and shoes for two of my students because they didn't know where they could go to access [the support]. They had just come [to Canada], they were isolated in their homes, everything was online, and at the same time, they were experiencing housing precarity and a [mental] health situation. Although students had health insurance from [their college] they would be refused to be seen at local doctor's office, most likely, I speculate that the doctor's office

> was not familiar with their insurance, I'm not sure, but they were refused. [Migrants rights organizations] can only do so much, and they are not frontline providers. I ended up doing settlement services for [my] students, which is ridiculous, like ridiculously ridiculous.

Mei describes the need to provide settlement services for international students as "ridiculous," highlighting the lack of comprehensive support for international students navigating healthcare services in Ontario. Street-level actors engaged as activists often feel compelled to assist without these supports, balancing this de/bordering work with their full-time jobs. This can lead to emotional distress and burnout (discussed in Chapter 8). Responding to urgent crises and providing humanitarian assistance, such as collecting essential items, was one strategy participants used when other support was unavailable.

Those on study permits face unique challenges, including limited and uneven coverage from educational institutions, which can leave them with large bills. CHCs are often unable to see international students, and this limited support forces international students and those advocating for them to pursue various strategies, such as social learning, relationship building, and resource mobilization (such as in Mei's case, collecting resources out-of-pocket or securing donations).

Migrants in the SAWP

Temporary migrant workers (TMWs) in Ontario are eligible for the Ontario Health Insurance Plan (OHIP); however, accessing healthcare can still be challenging due to bureaucratic, administrative, and structural barriers, including unclear information about workers' rights (Niraula et al., 2023). Participants identified the Seasonal Agricultural Worker Program (SAWP) – a stream of Canada's Temporary Foreign Worker Program (TFWP) – as particularly difficult to navigate when supporting migrants in the program. While SAWP migrants are formally eligible for provincial healthcare upon arrival to Canada, challenges to enrollment persist, including a lack of awareness about their rights and entitlements, limited communication from employers, and overall opacity of the program (CCR, 2016).[25] Even after securing health coverage, barriers to care remain, including lack of transportation to clinics or hospitals, and fears of lost wages, termination, or not being rehired for the next season as a result of seeking care or telling their

[25] For migrants in other TFWP streams, such as the (non-SAWP) Agricultural stream, until recently, there was a wait time to get health coverage of 3 months in Ontario (Government of Canada, 2025). This has been removed (with changes made during the COVID pandemic) until further notice (Government of Canada, 2025).

employer that they are sick (Hanley et al., 2014; Hennebry, McLaughlin, & Preibisch, 2016; Hennebry, Preibisch, & McLaughlin, 2010).

If they leave or are fired from their job, they can become non-status residents, increasing their risk of deportation (Amnesty International, 2025; Migrant Rights Network, 2021). This complex entanglement between employment and immigration status places workers in the SAWP in positions of systemic exploitation and discrimination, making it difficult for them to request health insurance from employers (Amnesty International, 2025; Migrant Rights Network, 2021; Preibisch & Hennebry, 2011).

Moreover, healthcare entitlements in Canada are managed in a fragmented and uncoordinated manner across multiple levels of government (Caxaj et al., 2024). As a result, the specific healthcare access needs of migrants on temporary work permits are not adequately addressed (Caxaj et al., 2024). For example, migrants on temporary permits often face challenges in securing time off to attend appointments, which typically coincide with work hours (Caxaj et al., 2024). Consequently, many seasonal agricultural workers face difficulties accessing healthcare, despite being theoretically entitled to it (Preibisch & Hennerbry, 2011).

In facing barriers to accessing healthcare, migrants often turn to CHCs for their healthcare concerns. However, many rural areas where migrants work in agriculture often do not have enough CHCs (Bobadilla et al., 2016; Caxaj et al., 2022; CCR, 2016). Kai, who worked in a rural CHC, noted his area's inadequate community support for migrant workers. Lacking formal support, Kai explained the importance of informal networks and CHC initiatives, such as having mobile health buses travelling to farms where migrants work. Other strategies included meeting people in places like malls or grocery stores, approaching them with flyers, or speaking about their organization and services. Kai also talked about involving his clients with precarious immigration status in community building, such as holding monthly get-togethers to share food and knowledge about services that people with lived experience have learned about, as well as holding events such as music nights or yearly soccer tournaments. In engaging in these forms of de/bordering work, participants built a sense of community with temporary workers, strengthening relationships and facilitating the circulation of social learning. They also help manage the emotional dimensions of their work.

Many participants viewed forming and maintaining relationships as a flexible strategy that could be used dynamically in times of uncertainty or urgency. Kai also described his de/bordering work as "trying to develop tentacles and reaching." As he explained this, he reached out his hands like octopus tentacles and said, "It's really doing this –" [he said this as he reached his arms out] "– and sometimes it doesn't work, but sometimes they work, and when they work, then you have more connections." Street-level actors engage in relational forms of praxis building and social learning through these connections.

Refugees and Refugee Claimants

Refugees are entitled to interim federal health (IFH) coverage, as are refugee claimants, while their claim is under consideration. They are thus entitled to certain healthcare services, including prescription coverage (Government of Canada, 2022). Clinics and pharmacies must register as an IFH provider to process IFH-related healthcare services. This requirement creates challenges for refugees and refugee claimants as health seekers, as it is up to them to identify providers registered to offer IFH services. Participants used various de/bordering strategies to ensure healthcare access for refugees and refugee claimants awaiting their claim outcomes. These strategies included building social relationships and using strategies acquired through social learning to find IFH-accepting clinics and pharmacies.

Despite being entitled to some healthcare services under IFH coverage, refugees and refugee claimants are regularly denied access to services and medications. Participants I spoke with had developed a working knowledge of which clinics, hospitals, pharmacies, etc. were familiar with the IFH program and who, based on experience, was willing to provide services. As Anne, a doctor in a clinic, explains, some pharmacies have not registered for IFH, which necessitates further advocacy to ensure that people are not charged and are aware of their rights:

> I have to be really careful when I'm counselling my patients if I'm giving them a prescription and it's their first time going to a pharmacy. I really tell them like, this medication is covered, you need to show your refugee ID – your brown paper. If they tell you that you need to pay, please don't. Call me back, and I'm gonna help you find a different pharmacy.

A strategy used by participants was developing a working knowledge of locations where people could receive care without trouble. This knowledge is based on connections and feedback from those with precarious immigration status:

> When [refugee patients live] close by to us, obviously there are pharmacies that I know that they can go to; our hospital pharmacy, for example, is well familiar with IFH. But, if I'm sending something to [a patient] in the community because our patients live in so many different areas, I would say the majority of pharmacies are familiar with IFH, but not all. (Anne, Doctor, Clinic).

Participants often referred patients to pharmacies with which they established relationships, ensuring these pharmacies were familiar with the IFH program. In addition to these individual efforts, activists often depended on informal arrangements to provide broader support for individuals with precarious immigration status. For instance, participants working in CHCs sometimes negotiated agreements with hospital staff to charge patients with precarious immigration status at the OHIP rate:

> When we send the referral letter for a non-insured client, it does say that you can charge [the participant's CHC] at the OHIP rate. But that might take a bit more administrative work, I guess, for them to send an invoice or whatever. So, there are a lot of clinics that will decline referrals because people are non-insured, or even IFH, even refugees sometimes because there's a bit of a longer process - they have to go through Blue Cross and some other funding and administrative work. That definitely does happen where consultants or clinics decline referrals because patients are non-insured or have IFH. And so, we have a list of people who are clinics or consultants, that we like to refer to because we know they take our clients…but it's not uncommon for us to hear back saying declined or whatever (Layla, Doctor, CHC).

As Layla's reflection indicates, even when formal workarounds are available—such as referring patients under the OHIP rate—significant barriers related to administrative burden[26] and provider willingness persist (Schmidt et al., 2023). These informal strategies often depend on available resources or institutional flexibility and how individual providers determine the "worth" and "deservingness" of care. This highlights how assessments of deservingness, influenced by time constraints, emotional responses, and perceived vulnerability, impact street-level actors' willingness to navigate bureaucratic hurdles. The emotional labour involved in these decisions is crucial to how activists facilitate access without equitable health policies.

Non-Status Individuals

[26] Specifically, here I am referring to the administrative burden placed on institutions in providing more equitable access, rather than the burden migrants navigating applications, government agencies, and other bureaucratic processes.

While individuals with university or college insurance, employer insurance, or IFH coverage may encounter obstacles in having their coverage recognized, those without any coverage, such as non-status individuals, may face even greater challenges accessing care. In these situations, non-status individuals are "really reliant on the small number of community health centres that provide for uninsured and who have some pockets of money for consulting care and diagnostics" (Anne, Doctor, Clinic).

When people are completely uninsured, participants adopt creative and strategic de/bordering approaches to negotiate medication access for patients, including using institutional resources and applying for funds to assist with costs. Theresa, a doctor in a CHC, discussed obtaining medication samples from pharmacy representatives. However, this method often resulted in receiving medications that were not consistently needed and would frequently expire. After encountering this, Theresa's CHC started negotiating directly with community pharmacists to secure supplies for uninsured individuals:

> We're careful…we can't just do everything, so we try to be reasonable…We have community pharmacists that work nearby so we consult with them and try to figure out the least expensive options. And we have two pharmacies that we've unofficially, or officially partnered with…community pharmacists, they will bill us directly and don't add fees.

In other cases, Theresa used compassionate funds at her clinic to cover medication costs for uninsured patients:

> I can think of [a patient] who needed a more expensive insulin. And we did get the compassionate coverage from the drug company for that. It made a big difference because otherwise, I think the amount she needed, we wouldn't have been able to cover it. So, in that case, it made sense to go to the drug company. We'll do that if needed. But I think generally we prefer to cover generic, less expensive medications, similar to what ODP [the Ontario Drug Benefit Program] would cover.

Compassionate funding, such as the Government of Ontario's (2023) Exceptional Access Program, is limited and requires extensive paperwork, as seen in the Government of Ontario's application procedure for coverage of drugs through compassionate means (Government of Ontario, 2023). Engaging with formalized policies of compassionate care requires activists to navigate and draw on familiar stories of deservingness, framing their patients regarding

vulnerability and need. This vulnerability is codified in the institutional language of these familiar stories, where some hospitals and clinics have dedicated funds for "vulnerable" patients, like those under-housed or without insurance.[27] This language, while highlighting the vulnerability of some at the expense of others, also reinforces and justifies an exclusivity codified in policy and acts as a bureaucratic form of gatekeeping. This complicates securing these funds, especially for street-level actors with limited time and capacity. Participants reported feeling constrained in the care they could provide due to time and resource limitations. They could only access these compassionate funds when no other options were available, and obtaining them can be time-consuming, with minimal payoff.

Hospital-based participants frequently depended on their networks and arrangements with CHCs to refer patients to more comprehensive care when they were unable to provide it at their institution. In the absence of primary care services for non-status patients, participants learned to anticipate their patients' needs to ensure they continue to receive necessary care. For example, Mateo, a doctor in a hospital, discussed referring non-status patients in his department who had chronic or severe care needs, such as diabetes, cancer, or mental health issues, to a nearby CHC with a specialist when funding for their hospital care was running out. Occasionally, he would keep patients a little longer if they could not immediately connect with a CHC, using compassionate care funds to help cover part of their medication costs. However, he generally aimed to connect them with a CHC after their first or second visit to the hospital.

In addition to managing chronic conditions, such as diabetes, participants assisted non-status individuals who required acute and emergency care. Participants in community clinic settings navigate tricky situations when patients wish to avoid hospital care due to fears of sharing their information with the CBSA or facing unaffordable bills. Participants discussed the moral dilemma of referring patients to the emergency department while respecting their refusal to go to the hospital.

For example, Emory, a doctor working in a CHC, described a case in which a non-status patient came into his clinic with severe skin burns that they had gotten while working at their

[27] For examples see: Humber River Hospital's Comfort Fund (https://www.hrhfoundation.ca/blog/new-emergency-patient-comfort-fund-will-help-our-most-vulnerable-patients/) or the Government of Ontario's Compassionate Drug Fund (https://files.ontario.ca/moh-compassionate-review-policy.pdf).

restaurant job. Emory knew they needed to be treated in the hospital and that imminent surgery was needed for the burns. However, when the patient would not go to the hospital due to having faced previous discrimination, Emory called his friend who works as a plastic surgeon and asked them if they would be willing to provide care to the patient at no cost. The plastic surgeon agreed to provide care to the patient as a favour to Emory, circumventing the person having to go to the hospital.

In recounting the story, Emory highlights the power of social connections, informal networking, and storytelling in securing care. Like Emory, other participants discussed leveraging their networks to call in favours, strategically using forms of de/bordering and familiar stories to frame their clients' deservingness and ensure comprehensive and continuous care for those they support. Within this patchwork of access, drawing on familiar stories of deservingness is thus a strategy for securing immediate, case-by-case support.

Cohen and Hjalmarson (2020) argue, speaking specifically about migrants' daily acts of resistance, that these subtle forms of resistance are important political acts in their own right.[28] Moreover, there is a connection between this everyday resistance and migrants' willingness or ability to engage in broader, more public forms of collective action, such as building networks, relationships, coalitions, and solidarity. This insight applies here as well. As Aurora discusses, the organization she helped build and develop, which foregrounds migrant voices and participation, aims to make this connection by providing in the moment survival strategies based on needs articulated by migrants themselves, while also participating in broader coalitions and solidarity efforts to organize and mobilize. These relationships of reciprocity, then, are not only tools of survival but also serve as foundations for broader advocacy and organization efforts (Cohen & Hjalmarson, 2020).

Those with precarious immigration status experience differential access to healthcare related to their immigration status and intersecting factors, including racialization, gender, sexuality, and class, contributing to processes of differential inclusion. Negotiating the pervasive context of systemic exclusion and processes of differential inclusion, participants developed and shared creative strategies to de/border, adapting their approaches based on contexts and the

[28] Cohen and Hjalmarson draw on Scott's (1985) work to argue that the scholarly emphasis on large-scale mobilizations often obscures the significance of everyday, quieter forms of resistance.

unique experiences of marginalization faced by those they are assisting. Activists often engage in collective de/bordering by identifying loopholes, leveraging broader networks, and sharing knowledge and resources. These approaches of using informal strategies to build networks and share resources highlight the relationality of this social movement work, as activists collaborate with a broader network of allies to secure healthcare access for those they support.

Balancing Discretion, Advocacy, and Ethics

Participants navigate healthcare access for individuals with precarious immigration status while contending with institutional and structural constraints that shape processes of differential inclusion. Using "out-of-the-box thinking" (Vivian, Nurse, Clinic), participants describe sometimes circumventing or even contravening state policies to meet urgent needs. While they openly discussed these strategies with me, they also emphasized the importance of keeping some strategies private. Participants explained that not sharing certain strategies publicly could help avoid negative consequences for those they support and protect against potential tightening of policies.

For individuals with precarious immigration status and their allies, the threat of outing these strategies can stifle opportunities for action. While I also agree with these participants' views and have chosen to be extremely careful in writing this chapter on strategies, keeping particular strategies under wraps can limit how knowledge is disseminated to those it can help. This is a continual challenge facing activists. How does one weigh both the harms and benefits of keeping these strategies from being far-reaching and accessible? How does one get the information out there to those who can benefit from it in ways that do not jeopardize the safety and security of those they aim to help? How can one foster trust and solidarity amongst those working to help people with precarious immigration status navigate access to healthcare?

There is no simple answer to these questions. One approach is to build networks of trusted individuals who can securely share information. Participants used strategies like holding meetings in 'safe' settings, sharing information among trusted allies, and conducting workshops to raise awareness and educate street-level actors. These methods can bridge knowledge gaps while preserving the safety and security of individuals with precarious immigration status.

Conclusion: The Power of Quiet Advocacy

Institutional and structural power relations—and the activist responses that challenge them—are constantly shifting. Such shifts reflect the "multidimensional, complex, and nuanced" processes of differential inclusion (Cohen & Hjalmarson, 2020, p. 144). Scholars in migrant health advocacy increasingly recognize the importance of expanding our definition of activism beyond "visible social change via organised resistance" (Campbell & Cornish, 2021, p. 128) to capture the everyday resistance that is "carried out just under the surface accompanied by public performances of subordination and deference to authorities so that it remains undetected" (Cohen & Hjalmarson, 2020, p. 144; Scott, 1989; see also Barber, 2008; McLaughlin, 2010). These performances of subordination may be what allow "quiet" protest to continue. Because these forms of resistance are rarely seen as political, they are often overlooked in policy and academic discourse (Cohen & Hjalmarson, 2020, p. 146). However, for marginalized individuals with limited resources and security, these "weapons of the weak" (Scott, 1985), are often the most secure ways of confronting exclusionary systems. Rather than confronting exclusionary regimes head-on, participants often engaged in quiet negotiations that work 'aslant' to dominant power structures (Campbell & Cornish, 2021; Cohen & Hjalmarson, 2020; Mulubale et al., 2021). Though these strategies often go undetected, these less visible forms of de/bordering can be considered radical political acts that create "hope and survival in the face of the refusal of recognition of human rights and social justice by the political establishment" (Campbell & Cornish, 2021, p.131; Cohen & Hjalmarson, 2020).

Despite Canada's formal commitment to a "universal" healthcare system, migrants with precarious immigration status are often excluded through policy design and implementation gaps. As one participant, Sage, explains, the Canadian healthcare system is "designed to deny [migrants] care in many ways." In the absence of a coordinated and inclusive system, activists creatively and strategically improvise, with their informal and ad-hoc strategies becoming indispensable for them to negotiate care. Activists often rely on personal networks, social learning, and relationship-building to help individuals with precarious immigration status navigate healthcare access. This chapter emphasizes the importance of these informal networks. It highlights the various de/bordering tools with which activists engage, the knowledge they develop, and the strategic responses they develop in response to the unique needs and

circumstances of those they support, recognizing the specific challenges posed by their immigration status and categorization.

Moreover, the chapter highlights the systemic issues that persist despite activism and efforts to mitigate migrant health inequities. These issues include inconsistent funding, limited resources and time, and administrative burdens, all of which exacerbate the challenges faced by both activists and migrants with precarious immigration status seeking healthcare. However, while informal and ad-hoc strategies serve as important in the moment facilitation of access to healthcare, as Segrave (2019) argues,

> The exclusionary scaffolding of the border regime is never undone, but it is often rendered less relevant in the everyday experiences of workers [migrants] and employers [supporters]. The nuanced and complex conceptualization of differential inclusion provided here recognizes that workers and employers utilize diverse strategies and sites to subvert state exclusionary practices. They construct support mechanisms within migrant networks, employment settings, and in their communities that make it possible for them to successfully negotiate everyday life, even within the context of exclusionary legal regimes (p. 207).

While these exclusionary systems may never be fully undone, in the chapter that follows I further explore activists' efforts to challenge these systemic exclusions by examining the broader de/bordering strategies (coalition-building and solidarity) that activists use in their work.

Chapter 7: Coalition and Solidarity Building

Coalition-building and solidarity are relational practices that take shape through activists' engagement with bordering spaces. They tell stories in these spaces, share strategies, and resources. Together, these practices help them foster knowledge production, shaping how they think, learn, and carry out de/bordering work. By acting in solidarity with one another and through building coalitions, activists refine their strategies through reflection, collaboration, and shared learning (Choudry, 2015). These processes involve engaging with stories of deservingness in ways that influence their strategic approaches and emotional responses.

Despite this intensive work, academic research often fails to recognize activists as learners or contributors to knowledge production (Choudry, 2015). This gap limits theoretical understanding of the complex, dynamic, affective, and relational ways in which activists generate and share knowledge, particularly how coalition-building and de/bordering strategies shape health policy and practice.

To address this gap, I ask: How do activists' de/bordering strategies for navigating healthcare access (for individuals with precarious immigration status) evolve in response to structural and institutional barriers, emotional challenges, and shifting contexts? What knowledge and praxis-building tools do they need to do this work effectively? How do activists navigate this emotional de/bordering work?

This chapter focuses specifically on the role of coalition-building and solidarity in shaping activists' strategies and knowledge production. Through an analysis of activists' emotional work, I offer insights into how solidarity and coalition efforts support activists in managing emotional distress, an issue I return to in Chapter 8. I argue that activists' de/bordering work is situational and evolving, influenced by the stories they hear and tell, and subsequent knowledge and praxis that emerge through collective efforts. This dynamic process not only shapes their strategies but also their emotional engagement with their work.

In this chapter, I challenge the dominant understanding in social movement scholarship of coalition-building as primarily a tool for collective mobilization (Van Dyke & Amos, 2017). While there is some social movement work that focuses on the knowledge production of activists, particularly by feminist scholars (Choudry, 2015; Kinsman, 2006; Whittier, 2021), it

mainly emphasizes political mobilization rather than individual emotions in coalitions and knowledge (Van Dyke & Amos, 2017; Whittier, 2021). Instead, I see activists as interacting with the social fields in which they engage, not simply as participants but as key actors, using storytelling, social learning, and emotional experiences to shape their knowledge and strategies in ways that aim to challenge institutional and structural barriers. Rather than simply navigating existing structures, activists also work to reshape them by resisting policies and practices that uphold exclusionary power dynamics. As Kinsman (2006) argues, whether recognized or not:

> Activists are thinking, talking about, researching and theorizing about what is going on, what they are going to do next, and how to analyze the situations they face, whether in relation to attending a demonstration, a meeting, a confrontation with institutional forces or planning the next action or campaign (p. 134).

Kinsman highlights the knowledge production that occurs in coalitions and spaces of solidarity, such as advocacy meetings. The role of storytelling and multiple de/bordering strategies used in these spaces is crucial, as they serve as key sites for action. In these spaces, activists gain power through solidarity, with the support of others amplifying their efforts and strengthening their influence. This perspective reveals that activists not only resist exclusionary immigration and health policies but also generate new knowledge in the process. They employ storytelling to foster relationships that shape advocacy across various contexts and refine their de-bordering efforts in ways that seek to disrupt power dynamics. Building on the work of Choudry (2015), Kinsman (2006), and other scholars who highlight the critical learning and reflective aspects of social movement work, I expand this scholarship by focusing on the role of stories, knowledge, and praxis in coalition and solidarity efforts. I draw on an interdisciplinary perspective to examine how activists' involvement in coalition work through storytelling disrupts exclusionary policies and generates new forms of knowledge, influencing their praxis and de/bordering strategies across contexts. This chapter also highlights the emotional dynamics that shape activists' de/bordering approaches. While often understood as sites of strategic collaboration, coalitions also foster emotional ties and relational support (Ransan-Cooper et al., 2018).

This chapter begins with a brief review of social movement literature of coalitions and solidarity, and background on the IFH protests and the PHSUP policy cuts as two prominent

im/migration health mobilizations in Canada. The last section analyzes participants' engagement in coalition-building and solidarity work. The chapter concludes by examining challenges to coalition-building and solidarity, including tensions between grassroots organizations and institutional actors.

Coalition-Building and Solidarity in Social Movements

Building on social movement literature about coalition dynamics, I examine how the bordering spaces where coalitions serve as sites of knowledge production where activists develop strategies for de/bordering, negotiating access and challenging health inequities faced by those with precarious immigration status. Chavez (2013) defines coalitions as separate groups coming together around a shared goal or issue.[29] Much of the existing social movement literature emphasizes collective organizing at the group or organizational level. My focus is on how individual activists engage in migrant health advocacy. In particular, I examine how coalitions foster knowledge production, social learning, and praxis.

Coalitions

Coalition-building and solidarity efforts foster relationships among activists who may have distinct goals, but collaborate to address shared concerns, such as healthcare inequities. For example, while organizations or movement actors may have different specific goals—such as advocating for universal prescription coverage, de-privatizing healthcare, or expanding access for individuals with precarious immigration status—they often unite around the broader aim of addressing healthcare inequities. In these coalitions, this relational aspect of collaboration is shaped by storytelling and knowledge production, allowing participants not only to work towards shared goals but also to continually refine their own and others' ideas of deservingness.

In this way, coalition-building work also requires emotional work, as activists navigate tensions and power dynamics, both within and outside of their work. Shared emotional experiences not only shape the sustainability of movements but also the knowledge and strategies activists develop to maintain solidarity (Summers Effler, 2010). These shared

[29] While I use Chavez's definition here, it is worth noting that in the late twentieth century, the concept was used by feminists, especially women of colour, people from queer and LBGTQ+ communities, and women from lower socio-economic statuses (Chavez, 2013).

emotional experiences can help sustain movements and coalitions while mitigating burnout (Ransan-Cooper et al., 2018; Summers Effler, 2010).

Coalition strategies also often shift depending on the contexts in which they operate. As Sandoval (2003) argues, coalition actors form a "differential consciousness," which lets them shift between ideologies (or stories) that inform strategies. This process of coalition-building is situational and evolving, operating like the "clutch of an automobile: the mechanism that permits the driver to select, engage and disengage gears in a system for the transmission of power" (pp. 88-89). In practice, coalition strategies change based on the specific contexts in which they are deployed. For example, during the COVID pandemic, when the PHSUP policy was in place, activists used a range of de/bordering strategies. Some of these strategies were similar to those used in response to the IFH cuts (described below), while others diverged, reflecting the shifting political and social contexts. These changes in strategies are explored further in the sections that follow.

Coalitions and solidarity work are not without challenges, such as when tensions arise between groups with differing values, priorities, and advocacy goals. Some scholars, such as Einwohner and colleagues (2019), argue that while solidarity is central to collective action, it is not easily achieved, arguing that "social movements are characterized not only by difference within activist ranks but also by power asymmetries that reflect broader domination and distrust" (p. 1). For instance, John, who worked as a doctor in a clinic, discussed some of these tensions saying:

> When you get into the protest or rally aspect of political organizing, everybody has a different comfort level… how much they're willing to put themselves on the line…Sometimes in the activist communities, people can judge each other, like, "oh you're not willing to put yourself on the line in this way to fight for this thing that you believe in? And I'm willing to get arrested, or I'm willing to like be part of violence." Everybody has their own ways of making change; everybody has their own bar, and comfort level and sometimes that can be tough to navigate when you're in an activist circle.

As John describes, people can have different comfort levels in terms of advocating. This is especially the case in considering migrant health advocacy where the intersection of racialization, immigration status, and other factors can make direct actions intimidating and dangerous, for those who are deportable. Understanding these affective, emotional, lived

experiences of diverse actors in coalition-building is thus an important factor to consider in social movement work at the intersection of bordering spaces.

At the same time, other scholars, like Brooker and Meyer (2019), argue that forming 'diverse coalitions' can be beneficial, especially if movements can navigate and overcome challenges posed by power differentials and inequalities such as those related to race, class, or gender (Brooker & Meyer, 2019; Gawerc, 2021). Despite the challenges of coalition-building, such collective action offers the opportunity to include many voices, viewpoints, and stories, in one space, from healthcare organizations composed mainly of healthcare workers, migrant-led organizations, and allied networks such as legal rights or labour unions. Engaging in a multi-level analysis of migrant health activists – one that incorporates the personal and emotional dimensions of coalitions – is therefore important to consider in social movement studies.

IFH Cuts and Removal of PHSUP Policy

As mentioned, coalitions are especially likely to form during times of crisis or threat because individuals put aside their differences to address an immediate issue or focus on a specific target (Van Dyke & McCammon, 2010). In this section, I describe two prominent moments in Canadian migrant health advocacy history: 1) the IFH cuts and subsequent reinstatement and 2) the introduction and removal of the PHSUP policy during the COVID pandemic.

The Interim Federal Health (IFH) cuts in 2012 were a particularly influential example of diverse members and groups coming together to form a coalition to reinstate IFH coverage for refugees in Canada. The cuts sparked a significant advocacy response, particularly from healthcare professionals (especially doctors), who mobilized in opposition to these regressive policy changes (Harrison, 2018). The IFH mobilization draws from similar "master frames" (Polletta & Ho, 2006) of human rights and humanitarianism discourses that recent migrant health movements also draw upon in their storytelling.

Many participants referenced the IFH protests as an influential movement in Canada. Rynwen, a doctor involved in the IFH protests, recalled that the mobilization by healthcare workers was unprecedented and unlike anything he or other long-time migrant health activists had seen. The protests began with a small group of doctors in Ontario who voiced concerns about the IFH cuts and eventually formed a larger network (Harrison, 2018). This group became

the Canadian Doctors for Refugee Care (CDRC) (Harrison, 2018). It engaged doctors across Canada in voicing their concerns over the IFH cuts (Harrison, 2018). Health providers initiated these mobilizations and also received support from 21 national medical organizations, including the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Canadian Association of Midwives, the Canadian Psychiatric Association, the Canadian Paediatric Society, the Public Health Physicians of Canada and the Canadian Association of Emergency Physicians. Each offered statements regarding the impacts of the IFH cuts (Canadian Doctors for Refugee Care v. Canada, 2015), working on the common goal of reinstating IFH coverage.

A second key advocacy moment occurred during the COVID pandemic, as activists organized vaccine clinics and COVID treatment for migrants with precarious immigration status. Similar to the response to the IFH cuts, some of the organizing I was involved in emerged in response to the PHSUP policy being introduced and later revoked. Recognizing this policy as temporary, a group of healthcare providers, researchers, and migrant justice activists formed to strategize ways of pushing for a permanent policy to address healthcare inequities facing people with precarious immigration status. This coalition emerged, in part, to push for the continuation of the PHSUP policy (which temporarily extended health coverage during COVID) and to advocate for a more permanent, inclusive healthcare policy for all residents, regardless of immigration status.

This coalition initially included healthcare providers and researchers who framed the issues through data, research, and front-line perspectives. Migrant-led groups later joined to help broaden the focus, emphasizing perspectives from lived experiences, the human rights dimensions of healthcare inequities, and connections to precarious immigration status. Together, this coalition brought complementary viewpoints to their advocacy efforts. While healthcare providers and researchers contributed institutional knowledge, migrant-led justice activists (comprised of individuals living with precarious immigration status) contributed to the knowledge agenda by highlighting the urgent human rights aspect of the issues, thereby strengthening the coalition's overall message. Despite the diverse backgrounds and sometimes conflicting viewpoints of the members, they unified in advocating for a broader inclusionary healthcare policy.

Coalition De/Bordering Strategies

Coalitions are a vital tool for social movements as they allow groups to combine resources and knowledge, leading to more ambitious actions that attract media attention and increase visibility (Brooker & Meyer, 2019; Gawerc, 2021; Heaney & Rojas, 2008; Tarrow, 2005). For example, during the IFH protests, participants used collective strategies, such as protesting and occupying the Health Minister's office. Similarly, in advocating for comprehensive and permanent healthcare for people with precarious immigration status during the COVID pandemic, activists used strategies like those employed in the IFH protests, including occupying space. Several rallies were held in front of Queen's Park and outside Health Minister Sylvia Jones' office to draw attention to the issue and call for comprehensive and permanent healthcare for all.

In the following section, I examine migrant justice and health organizing advocacy that shaped the movement spaces in which participants engage. These spaces varied in terms of leadership, particularly regarding the involvement of individuals with precarious immigration status. In some migrant justice groups, leadership consisted of people who have lived experience with precarious immigration status, which I refer to as 'migrant-led justice groups.' This distinction is important for understanding the context in which participants worked, the tensions that arose in different spaces, and the dynamics of solidarity and coalition-building. I divide the analysis of these two case studies (IFH and PHSUP cuts) into four sections: 1) how participants engaged in social learning and praxis-building, 2) coalition-building and solidarity across differences and tensions, 3) navigating institutional constraints of day-to-day advocacy while engaging in challenging broader structural barriers, and 4) participants' reflections on power, privilege, and their use of strategic solidarity.

Social Learning and Praxis Building

During my analysis of interviews, a set of retrospective questions emerged: How do activists reflect and learn from different contexts, including interactions with institutions and actors over time? How do they learn from past mobilizations? Specifically, in calling for the reinstatement of the PHSUP policy, what lessons can we learn from the IFH mobilizations and similar historical efforts? How can activists' knowledge, social learning, and praxis be mobilized across different moments in time to strengthen future collective actions?

Because these questions arose after interviews had concluded, they were not explored in depth with participants and cannot be fully addressed in this dissertation. However, this section explores the broader role of reflection, learning, and praxis-building in activists' coalition-building work.

Participants highlighted reflection and documentation as key to their advocacy, as forms of storytelling, and tools for informing their work, over time. For instance, while speaking with Rynwen, I asked what we could learn from the past mobilization for reinstating IFH and why he thought the protests were successful. As Rynwen said:

> We stuck to that one issue, and it allowed us to build a really broad coalition. There are people who voted conservative who came to and spoke at our protest. People who represented organizations that wouldn't generally be thought of as advocacy organizations. But it may have [been] different from you and I, and how we feel around other issues that pertain to immigration. But they were in our umbrella. I mean our group was at times condemned for not addressing other issues that involved immigration and refugee protection. But, I think, in retrospect, that strategy served us well.

The IFH protests' strategic focus contributed to their success and highlighted the importance of preserving activist knowledge for future mobilizations. Without systematic documentation, valuable strategies risk being lost, limiting the capacity for future activists to build upon previous efforts. This issue was raised by Aurora, a community organizer, who emphasized that activist spaces often struggle with archiving their work, leading to a loss of movement histories. She explained:

> I don't think something we [activist communities] do is document our work very well and have archives, and that's where I feel like researchers and research could have a role in terms of archiving work. We need to keep a history of things because things don't get passed on. That's something we do at [our organization] is heavily document, just so that we have it, can share it with others… [these] groups and spaces don't necessarily have to last for 20 to 30 years… [but] we need to make the assessments in these spaces and groups. Does it make sense to continue? And if it doesn't make sense to continue, archive that stuff, and then other groups can learn from what worked, didn't work, but also look at the moment, at what's happening now…that's what's been really helpful, by being in these other spaces, we've [as an organization] learned what not to do, and what to do. But, if it wasn't for us being in those spaces, we wouldn't have learned them. And I'm sure there have been so many

> other undocumented groups, and we'll never know because it wasn't documented, and that's where I do find research can be helpful.

Reflections and knowledge gained from past movement work can promote social learning among movements and coalitions. Documenting these experiences also facilitates emotional reflexivity and creative strategizing in advocacy work, both of which are important aspects of movements that often receive less attention due to more urgent or emergent issues (Choudry, 2020; Ransan-Cooper et al., 2018). However, as Aurora states, documenting this work is a valuable way to learn from experiences of what has worked or not worked in other migrant health justice spaces. Participants identified self-reflection, both individually and collectively, as essential for building praxis in movement spaces. In this process of retelling stories, knowledge and praxis are produced and shared.

I also observed this reflection and documentation in my involvement with activist work. In one migrant justice organization I am involved in, we spent a year discussing our internal group values, priorities, and outreach goals in each monthly meeting. From this work, we created and documented updated terms of reference for the network. Additionally, we organized an online webinar reunion of the network, during which we had members who helped form the network reflect and discuss among participants. Throughout the meeting, while the founding members were speaking, we had a visual artist map out the conversation to memorialize it creatively. Reflecting on and sharing stories of past mobilization efforts helps movement actors construct their activist identities (Jasper, 2018). According to Jasper (2018), this reflective work combines positive and negative emotions, such as anger and joy. Activists may feel anger in response to a common threat while also experiencing joy during moments of reflection or when sharing meals as a group (Jasper, 2018). These ranging emotional responses can motivate and sustain collective action, as well as shape the stories people individually and collectively tell, influencing their individual perspectives on their activist work (Jasper, 2018). Engaging in emotionally reflexive practices as a network can be a powerful de/bordering strategy. These practices allow activists to learn collectively and individually, generate knowledge, and adapt practical strategies for their advocacy work.

Navigating Tensions and Challenges in Coalition-Building and Solidarity Efforts

Many participants highlighted tensions between individuals and groups advocating with diverse strategies and goals in mind. These tensions emerge when activists hold differing views about the most effective or ethical ways to ensure healthcare access for people with precarious immigration status. These views range from institutional or policy-based advocacy strategies, such as education and training in workplaces, to "backdoor" lobbying to policymakers (Appendix C). Others emphasize humanitarian or direct service-oriented approaches to address urgent needs as they emerge. Still others draw on public mobilizations and broader coalition-building to demonstrate collective support and raise awareness of issues.

Ongoing tensions between advocacy groups can hinder effective collaboration and solidarity (Beamish & Leubbers, 2009). Many front-line worker participants found that day-to-day advocacy strategies, such as addressing the immediate needs of individuals with precarious immigration status, were more feasible within their work constraints. In contrast, broader-level advocacy, such as attending rallies, participating in demonstrations, or engaging in public awareness,[30] was often less accessible. Within the bureaucratic confines of healthcare settings, street-level actors often struggle to align their priorities with those of broader systems-level advocacy groups. These challenges can stem from a lack of awareness or concrete ideas about how to address the broader issues shaping dynamic processes of differential inclusion for marginalized individuals. For many participants, this feeling of being limited also contributed to emotional tension and distress, including frustration. For example, Layla, a doctor in a CHC, explains that when confronted with broader structural barriers in her daily work, she felt unable to fully address these broader issues due to institutional constraints such as limited time and resources:

> I can tell somebody they have diabetes, and I can tell them to go eat healthy, but if they live in a shelter and they tell me, "Well, you know what, all we have is like big bowls of carbs, like rice and pasta, I don't know what else to eat." That's where we struggle, and I say, "Well, you're right. I don't know what to tell you…I'm asking you to make healthy food choices, but you don't really have control over the food that you're served or [that] you can't afford healthy options." It's one thing to understand the impact, but sometimes it's like, what can we do – practically speaking? Yes, we can refer to all these partners and resources, but again, sometimes you're limited by [your] own funding or their

[30] Examples of raising public awareness included hosting webinars, organizing educational campaigns, and recruiting new members form the public or coalition allies to strengthen advocacy efforts.

> own limitations…It's higher-level intervention that needs to happen, policy or research…We need this kind of bigger change to happen.

As Layla describes, institutional constraints – such as time/resources or restrictive policies and practices – impede efforts to address broader systemic issues in daily practice. Layla, like others working in contexts with limited funding for migrants with precarious immigration status, emphasized the importance of connecting people with supports so that they could receive ongoing care, as soon as possible, after the first or second appointment. In these cases, solidarity and broader coalitions played a crucial role. For many participants in low-resource settings, these informal connections were often the only means to ensure that those they support were able to secure access, and thus these relationships became invaluable.

These structural challenges also emerge in movement spaces, where individuals with precarious immigration status are often underrepresented in advocacy efforts conducted on their behalf. Tensions related to ideological, structural, and resource issues have been identified as barriers to collaboration and coalition-building within and across movements (Beamish & Leubbers, 2009). A significant challenge and tension in solidarity and coalition-building is the lack of cooperation between migrant health activists who lack experience with precarious immigration status and those who possess this lived experience. This disconnect excludes critical insights from those most directly impacted, creating barriers to inclusion and limiting the diversity of strategies available. Advocacy often fails to address the most pressing issues for those with lived experience and misses opportunities to tackle the root causes of inequities.

Power, Privilege, and Strategic Solidarity

Including voices and stories from individuals with lived experiences of precarious immigration status is vital in advocacy and movement work, as it ensures the involvement of those most affected by these issues. However, tensions can arise within coalitions due to differences in privilege and power. These dynamics affect whose voices are prioritized in advocacy agenda setting. In coalitions, those with the greatest social, economic, and political privilege (often white citizens and permanent residents in migrant health advocacy spaces), tend to have greater influence over coalition agenda setting. This reflects broader structural inequities, in which power and influence are unequally distributed. This can marginalize the voices of migrants with

precarious immigration status, often shaping coalition priorities in ways that do not reflect their needs or perspectives.

This lack of representation of migrant voices was discussed by Aurora, who mentioned that in one migrant health organization she was a part of:

> I didn't get a feeling from the others in the space that it was a priority for migrants being in the space. And I just don't think gainful wins are won without the people that are being directly affected. And some of the demands, approaches, and tactics being used were more informed by backdoor approaches, like talking to the Ministry of Health, making connections there, doing some sort of public advocacy through press conferences, educating physicians, on how to facilitate access to services for undocumented people…

Frustrated by these dynamics, Aurora helped create a new migrant-led organization that directly involved people with precarious immigration status in their advocacy work. While she herself did not have the experience of living with precarious immigration status, her co-creator of the organization did, and the organization facilitated meetings, dinners, and messaging threads to enable their members to identify their own needs and shape the direction of advocacy efforts. But Aurora also emphasized the importance of maintaining connections with other networks. As mentioned, while network priorities may differ, they often work towards a shared goal using diverse approaches (Gawerc, 2021).

Aurora reflects on the process of building a new organization, while also engaging in broader coalition-building, stating the following:

> In this space, we really focus on building the trust and safety, and then we are connected as [our organization] to [a national] network of migrant groups from across Canada that mobilize migrant members. We try to mobilize our members to be a part of this national network to push for fundamental changes to the immigration system, a complete overhaul ideally of the immigration system, while also addressing their survival needs. I never felt that there was a space that did both …survival needs [and also] pushing for dismantling some of these systems… connecting with migrant communities, or supporting their everyday needs. So, this is how [their organization] kind of naturally started, and we tried not to have a direction at the beginning, because we did want the direction to be facilitated by the members themselves.

In other cases, when migrant voices were not present, participants incorporated those individuals' stories and experiences into their advocacy work by gathering and sharing them as

part of their efforts. Stories of lived experience can "mobilize support and participation, elicit empathy and understanding among authorities and potential allies, [and] forge coalitions across differences" (Polletta, 2006, p. 178). However, Polletta (2006) also argues that activists must recognize how relying on familiar narratives can limit their strategic options (Polletta, 2006). As discussed earlier, exclusively relying on lived experience stories of deservingness can reinforce dominant discourses, such as linking deservingness to citizenship and permanent residence or perpetuating narratives of migrant victimhood and their portrayal as a burden. Despite these limitations, engaging with these stories creatively and strategically can be valuable in specific contexts, as they may be used to elicit emotional responses or influence policy debates. This tension highlights the need for adaptable de/bordering approaches—supported by a conceptual framework that reflects this flexibility—functioning like the aforementioned shifting car clutch, enabling activists to deploy them as circumstances arise selectively.

Participants without experience living with precarious immigration status expressed several strategies to root their work in collaboration and consideration of those with lived experience. Aurora, for instance, viewed her role in the grassroots organization she formed as intervening when structural barriers, such as racism and discrimination, hindered access to care for those with precarious immigration status in her organization. As she states:

> Sometimes there is a role for me, especially because we know that accessing services can be directly linked to your accent. Actually, we find that a lot, service providers in specific institutions can be very racist to people's accents. So, sometimes I have to step in and use my non-accented voice to be able to facilitate [access].

Aurora's strategy – using her "non-accented" voice to intervene – addresses the immediate impact of accent-based discrimination in healthcare (Leech et al., 2019). However, it does not directly challenge the structural causes of racism and discrimination. This reflects the complex reality that activists, in trying to support marginalized individuals, may sometimes perpetuate the power relations they seek to dismantle. In this case, the legitimacy of using a "non-accented" voice reinforces the legitimacy of healthcare and im/migration bordering, even while mitigating the immediate barriers to care. As such, activists can also be complicit in perpetuating (sometimes out of necessity) the power relations in which they aim to reject, as in

this case, the authority of language in “us” and “them” and the legitimacy of a “non-accented” voice.

Although this additional unpaid work—creatively and informally negotiating care—can be time-consuming, activists often find it brings about a stronger sense of accomplishment and satisfaction than broader systemic efforts like organizing rallies or conducting formal teaching and training. Participants emphasized the dynamic interaction between day-to-day and broader-level advocacy, highlighting the significance of both in de/bordering solidarity work and showing the mutually exclusive aspects of this work, where strategies shift over time. Fostering coalitions involves interactions with individuals and groups influenced by both historical context and current opportunities and constraints (Van Dyke & McCammon, 2010). These coalitions occur both in broader social movement organizing and in activists' day-to-day work. In both, activists can be limited by institutional and structural constraints related to capacity, resources, and time. In these shifting contexts, examining the relationality of activists de/bordering work across various contexts is important, as they adjust their strategies depending on their immediate goals and emotional bandwidth. Much like shifting gears in a vehicle, activists situationally adapt their strategies to address issues as they arrive in varying contexts in both situational and creatively strategic ways.

Engaging in solidarity work in institutional and activist spaces can deepen one’s connection to the broader systemic issues people face when seeking healthcare. For example, John felt that involvement in broader-level advocacy made him a more compassionate and “holistic” provider:

> When you're sitting in front of somebody in a clinic room, sure you can talk about their cholesterol or their blood pressure…but, what about racism and patriarchy and what about their migration status and what about income and gender and all of these other factors that have a much bigger impact on that person's health than what medications they’re taking? Everybody should be taught a lot more and be given opportunities, probably in experiential ways too, to learn a lot more about the [social] determinants of health, of which I consider [migration status to be] one of the [social] determinants of health because it absolutely influences how you work with a person that's sitting in front of you. It's not just “Oh, you have to take this medication…or you have to increase your exercise”… It's people and their lives, and their stories are just very, very complicated. And I hope that it makes me like a more empathetic

> person when I'm providing care, more understanding and holistic in my approach to medicine.

This idea of being "holistic" was discussed by several participants, who felt that their advocacy work provided continuous learning and reminded them to consider broader structural barriers and intersecting challenges of health inequity. Hope, who worked as a midwife in a clinic, noted that her background in systemic-level advocacy helped her maintain her principles when providing care, stating that "this is about equity and access and about the right to healthcare, rather than thinking through the dynamics of finances that can get so convoluted." For Hope, adopting a broader systemic-level approach, despite the constraints in the Ontario healthcare climate, was a means of aligning her values with her desired care approach. It is also important to consider that midwifery offers greater flexibility in advocacy compared to other health professions.

By linking both individual and systemic advocacy, this work shows how the emotional dimensions of activism, particularly in relation to individuals with precarious immigration status, shape activists' de/bordering strategies. These dynamics drive evolving actions, illustrating the complex relationship between grassroots work and structural challenges in healthcare advocacy. Adopting this interconnected approach helps us better understand how emotions in social movement work foster relationship-building, inform future advocacy, and enhance praxis.

Conclusion: Coalition-Building and Solidarity in Activist De/bordering Efforts

In this chapter, I examined how activists navigate institutional exclusions by engaging in coalition-building and solidarity, using storytelling, emotional reflexivity, strategic de/bordering, and resource leveraging to support knowledge production, praxis development, and social learning. I addressed this by asking: how do activists' strategies evolve in response to shifting barriers, shifting contexts, and emotional dimensions? What tools do they use to support ongoing advocacy? And how do they navigate the emotional aspects of their work? As I argue in this chapter and Chapter 6, informal strategizing is connected to broader coalition building; these two tactics intersect as activists navigate the dynamic contexts of their work.

Activist's de/bordering strategies are situationally dependent, shifting like a car clutch, in response to political terrain and institutional pressure. As participants form coalitions and engage in solidarity work, the knowledge they generate and share informs key decisions, including when

to mobilize, when to reverse or take a step back, and when to pause or "park". These decisions are not only shaped by past experiences, emotional reflexivity, social learning and praxis building that inform this knowledge production. I demonstrated that while coalition dynamics can involve tensions and unequal power dynamics, they also act as important sites of collaboration where shared goals are pursued and where activists engage in an ongoing, iterative process of refining their own stories of deservingness. This process is grounded in emotional reflexivity, which plays a key role in how activists generate knowledge and adapt their strategies. By centring IFH and PHSUP cuts case-studies, this chapter traced how moments of disruption and resistance, such as calls to reinstate PHSUP, demonstrate the ongoing role that individual and collective social learning and praxis continue to play within migrant health advocacy. These forms of praxis and social learning help activists navigate institutional barriers to healthcare, particularly for those with precarious immigration status. By reframing coalition-building not just as a tool for mobilizing but as a site of emotional work, knowledge creation, and strategic innovation, I highlight an often-overlooked dimension of advocacy work.

These findings expand bordering and social movement scholarship by centering the contextual, relational, and emotional dimensions of migrant health advocacy. By showing how activists develop tools such as storytelling, network leveraging, and reflexive practice, I offer insights into how they creatively resist healthcare exclusions in their everyday (Chapter 6) and broader (Chapter 7) de/bordering work. As I argue in Chapter 8, activists' de/bordering work is not only a site of collaboration, creation, and knowledge production, but also one that is emotionally taxing, often unpaid, and difficult to sustain. I demonstrate how the relationships formed through coalitions and solidarity enable activists to manage the emotional distress they encounter in this work.

Chapter 8: Emotional Distress

This chapter examines how activists experience and manage emotional distress, extending the analysis of coalition-building and solidarity introduced in Chapter 7. To examine my research question on how activists handle this distress, I focus on the interaction between coalition-building and emotional distress. Drawing on existing literature and my interview data, I argue that while engaging in advocacy contributes to emotional distress, the relational aspects of coalition-building, such as fostering connection, not only help mitigate that distress but also allow activists to feel less alone in challenging systemic barriers to healthcare access. In what follows, I explore how identity-based expectations (related to gender, racialization, etc.) and institutional constraints shape activists' experiences of distress and how they manage this distress, particularly through their coalition-building and solidarity work.

As Mei, a program director, describes, the emotional toll:

> [It is] a horrible situation for both [activists] and clients [discussing the COVID-19 context]. [Activists] are overworked… burnt out…when you are working frontline and have to refuse service – you know how this is going to impact your client – [especially if you] already have a relationship with them. This is also severely impacting the mental health of frontline workers at the moment.

Mei's reflection captures the immense emotional burden activists face when institutional constraints force them to deny care. Building on earlier chapters' focus on strategic de/bordering strategies, this chapter shifts the lens to the emotional consequences of that work, specifically, how emotional distress shapes activists' ongoing engagement in advocacy.

Emotional distress among healthcare workers has been documented extensively in health research and recognized by activists on the ground since at least the 1980s (Wilkinson, 1987). While as Mei mentions, the COVID pandemic may have heightened emotional distress, the underlying struggles have persisted for decades and continue to impact street-level actors' well-being.

Most literature on moral and emotional distress focuses on health and social work, emphasizing how linking one's work to broader structural issues can mitigate distress (Jawed et al., 2021; Maslach, 2017; Olcoń & Gulbas, 2021). Building on my existing research, I argue that

the relationship between emotional distress and advocacy work is deeply interrelated, with each informing the other. This interplay shapes how activists make decisions about who receives care, when, and why, as well as how exclusion occurs, either implicitly or explicitly in these decision-making processes. This relationship reveals the dynamic and shifting nature of deservingness. Activists' ideas of who is deserving are non-binary and multi-dimensional, responsive to changing emotional and contextual factors, including the extent of their distress, and the relationships they can draw on. While participants involved in broader advocacy used distress-related words frequently, they also expressed that this broader advocacy work was meaningful to them because it helped connect their daily work to larger structural issues, which, in turn, helped them cope with emotional distress. While broader advocacy did not necessarily reduce distress, it offered an arena in which to connect daily struggles with systemic issues and served as a coping strategy for them to manage the distress they felt.

Moral distress arises from the tension between institutional constraints and internal moral values (Čartolovni et al., 2021). While constraints in activists' daily practice can generate such distress, broader advocacy work, grounded in coalition-building and solidarity, offers a way to both manage these emotions and reframe them. Rather than viewing their distress as an individual problem, activists understand it as a shared response to systemic injustice, one that can be addressed through collective engagement. This reframing not only supports emotional coping but also shifts the focus from individual struggle to collective resistance.

Building on this conceptual framing, in this chapter, I provide a brief review of how emotional distress and emotions have been discussed in social movement and bordering literatures, with a focus on how they relate to migrant health advocacy. I then examine how participants experience emotional distress, the challenges they face, and their coping strategies. I will also explore the role of broader advocacy in activists' experiences of distress and consider gender and racialization, given that service work, caregiver, and volunteer work often involve women, particularly racialized women (Smith et al., 2022).

Moral and Emotional Distress in Social Movement and Bordering Literature

Contemporary scholars often make an epistemological choice to avoid framing protest in terms of "emotional distress" (Goodwin & Jasper, 2000) because research on social movements

emerged in opposition to the collective behaviour tradition in sociology and social psychology,[31] which framed protest as a psychological response to stress, dysfunction, or negatively associated emotions like "irrationality" (Goodwin & Jasper, 2000). My aim in discussing emotional distress in the context of social movement work is not to revive these psychological theories, which have been widely criticized for being pathologizing and lacking substantial empirical evidence (Jasper, 2011; Goodwin, Jasper, & Polletta, 2000; Goodwin & Jasper, 2006). Instead, I draw on theories of emotion and storytelling by social movement scholars like Jasper, Polletta, and Goodwin, to bring emotion and affect into new domains—specifically, bordering studies and migrant health advocacy. I examine how emotional distress is experienced in the context of migrant health advocacy and how activists' broader de/bordering efforts, including coalition-building and solidarity, shape how they understand, navigate, and respond to this distress. These processes include the strategies activists use to manage emotional distress, the actions they take in response, and how their engagement in broader advocacy efforts helps them feel connected to a larger movement, challenging systemic inequities in healthcare access.

While health scholarship has examined moral and emotional distress among street-level actors, like healthcare workers, the emotional experiences of migrant health activists – who occupy a range of roles within varied institutional contexts, remain largely unexplored (Pirkkalainen, 2023; Sotkasiira & Ryynänen, 2022). By focusing on these affective/emotional dimensions of activists, I contribute to a more robust understanding of how activists emotionally navigate and challenge systemic exclusions in healthcare.

Moral distress refers to knowing the right moral actions but being unable to act accordingly due to institutional or systemic constraints (Smith et al., 2022; Weinberg, 2009). Jameton (1984) framed morality as a gendered phenomenon, with collective action serving as a response to injustices in nursing. Individuals lacking support may experience moral distress, leading to burnout, job dissatisfaction, and the desire to change or leave careers (Weinberg, 2009). Critics of the concept argue that "morality" implies a singular correct action, disregarding the autonomy and agency of street-level actors (Smith et al., 2022; Weinberg, 2009). Therefore, I

[31] See for instance, Robert Merton's (1938) strain theory, Neil Smelser's (1963) value added theory, and Killian and Turner's (1972) emergent-norm theory on collective behaviour.

use the term “emotional distress” to better capture the nuances related to activists' inclusionary de/bordering and the emotional dimensions and challenges of this work.

Exploring emotional distress enables an examination of the dilemmas and tensions faced by activists, including their emotional states (e.g., anger, sadness, and happiness) in response to changing contexts, as well as their affective states, that is, the underlying positive or negative feelings linked to these emotions (Jasper, 1998). This approach also makes visible the intersectional challenges activists face based on their positionalities, such as being a woman, racialized, and/or living with precarious immigration status.

Recent studies in social movements and social psychology literature highlight the role of emotion in the emergence, maintenance, and decline of social movements (Flam & King, 2005; Goodwin et al., 2004; Goodwin & Jasper, 2006; Jasper, 1998; 2010; Klandermans, 2011; Rodgers, 2010). Since the 1990s, there has been a renewed focus on the emotional dimensions of social movements (Pirkkalainen, 2023). However, much of this research has centred on activists with secure legal status, such as citizenship or permanent residence (Pirkkalainen, 2023). Pirkkalainen’s (2023) work on anti-deportation activism offers an important exception, showing how affective and relational practices between asylum seekers and Finnish supporters produce “affective value” that sustains solidarity formations.

Solidarity and coalition-building arise from the specific institutional and social contexts where activists and individuals with precarious immigration status navigate their advocacy work, shaped by the institutions they interact with and the networks they build. These environments foster knowledge sharing and strategies that help manage emotional distress by providing a sense of connection and alignment with broader advocacy efforts (discussed in detail below).

Understanding Emotional Distress Faced by Activists

While many people engage in advocacy work because it feels meaningful, it can also create feelings of inadequacy and emotional distress rooted in institutional and structural obstacles. To assess participants’ distress, as mentioned in Chapter 4, I conducted an analysis of distress-related words used by participants. The frequency and relative prevalence of distress terms provided a systematic way to contextualize how participants expressed distress in their narratives.

Figure 3 provides an overview of the most frequent words participants used to describe feelings of distress,[32] where, as illustrated, participants often expressed emotional distress using language such as "upset," "sad," "difficult," and "hard." A common theme among participants was feeling they could not tackle the systemic barriers sustaining health inequities alone, yet several also described feeling empowered once they recognized these barriers as systemic, requiring collective rather than individual responses. For instance, as I describe in the section below, one participant, Sol, explained that her broader advocacy involvement helped her to feel like she held the power to make a change amidst the constraints and distress she faced.

Figure 3: Frequency of Words Related to Emotional Distress

Participants coped with feelings of distress by disengaging from their day-to-day advocacy work as much as they could, and becoming more involved in broader systemic advocacy efforts, which can in some sense, be removed from the impacts of direct, individual engagement with people facing exclusions. Unlike prior findings which suggest distress leads to withdrawal from advocacy (Weinberg, 2009), participants in this study often channeled their feelings of distress into broader systemic efforts. Although engaging in advocacy did not

[32] I identified word related to emotional distress and then tabulated them using MAXQDA software.

necessarily reduce participants' distress,[33] it provided an outlet for connecting their struggles in negotiating care to broader structural issues.

Activists' experiences of emotional distress also vary across temporal/historical contexts. For example, while distress intensified during the pandemic due to heightened challenges, it is rooted in broader, pre-existing systemic pressures within Canadian healthcare institutions, such as feeling unable to do enough or effect meaningful change due to time and resource constraints (Alonso-Prieto et al., 2022). These pressures are compounded when advocating for individuals with precarious status who face limited entitlements and significant barriers to accessing care. Sociolegal precarity reinforces systemic exclusion and health inequities, creating conditions where formal channels of care are inaccessible to many marginalized individuals. As a result, activists must rely on creative and often time-consuming strategies to negotiate care informally. Participants described the emotional demands of this work, not only navigating institutional constraints but also managing their own sense of responsibility and frustration in response to the structural barriers and processes of differential inclusion experienced by those they support.

Gender and Racialization: Impacts on Emotional Distress

Emotional distress occurs when structural and institutional barriers limit street-level actors' capacity to act in ways that align with their moral and value systems, barriers that are often experienced differently based on one's social location, including intersectional factors related to racialization, gender, immigration status, etc. The frequency and intensity with which individuals felt compelled to engage in advocacy was also, in part, shaped by these identities. Sol, who identified as a woman of colour, noted that many of her patients experienced issues stemming from structural barriers. This situation prompted her to question concepts of power, including who has the authority to decide who can enter, stay, and access rights in Canada. She stated:

> When I look at my clients with precarious immigration status, systemic factors are written all over those situations. The bureaucracy and challenges that come with filing paperwork…to me is a systemic thing. And the fact that we [as Canadians] even get to decide who has the right to be here…is a problem. Because we are settlers making these decisions on this land, that's something that always gets under my skin, especially when people get refusal letters or denial letters saying that they can no longer be in this country. It brings back this bigger question of who has the power and why they have the power to

[33] This statement is based on retrospective data. I did not design or conduct a longitudinal study, which could have tracked participants' advocacy and distress over time due to time constraints and the scope of the dissertation.

> make these decisions over people's lives. Who gets to decide that someone's application for refugee status on humanitarian grounds should be denied because it's not serious enough?

Sol's statement highlights the larger systemic barriers that activists have to negotiate within and create loopholes to navigate around. Familiar stories of deservingness are reinforced through institutional and structural discourses determining who is considered "worthy" of residing in Canada and receiving health services. These power dynamics and hierarchies of deservingness shape individuals' experiences of differential inclusion and activists' perceived capacity to effect change within their workplaces.

As a result, many participants sought out advocacy opportunities outside their primary places of work as spaces for solidarity and collective action, enabling them to challenge health inequities and experiences of differential inclusion for those with precarious immigration status. This broader advocacy often involved building new networks, forming coalitions, and engaging in solidarity work, contributing to social change. For example, in addition to her day-to-day work, Sol participated in an advocacy group focusing on anti-black racism to address individual and structural inequalities. She found her involvement in this advocacy community beneficial, as it provided a sense of being part of something larger and making meaningful change. The role and importance of this broader advocacy is discussed in greater detail in the last section of this chapter.

Moral or emotional distress tends to be higher among women than men (Smith et al., 2022). Smith et al. (2022) explain that this higher association between moral distress and women can be attributed to the gendered and patriarchal structure of healthcare systems, in which women are more likely than men to be in roles that involve close contact with patients, yet have less access to decision-making positions as administrators, nurses, social workers, and midwives. Additionally, the normative expectation that women take on caring roles remains prevalent. In these roles, dominant gender norms dictate that women exhibit emotional sensitivity, a demand not similarly placed on men (Smith et al., 2022). In these roles, individuals are expected to display emotional sensitivity, and the emotional labour associated with their assigned tasks can result in heightened feelings of emotional distress (Hochschild, 1984). As Lo and Nguyen (2021) argue:

> … [the] burden to care for allegedly "undeserving Latinx immigrants" is likely to fall disproportionately on Latinx healthcare professionals. Indeed, minority professionals, in general, have engaged in the work of bridging community needs and mainstream institutional resources and regulations as public institutions continue to reproduce patterns of racial marginalization despite official cultural competency training and initiatives. Motivated by a sense of linked fate, an immigrant narrative, or other discourses of ethnic solidarity, black and Latinx professionals often take it upon themselves to perform the equity work overlooked by their institutions (p. 2).

This invisible, unpaid, and often unappreciated work goes largely unnoticed by others in institutions and the community. It can add to the challenges and burdens that racialized women already face in their lives and careers, which also arise from interpersonal and institutional racism (Lo & Nguyen, 2021). When working to provide care to those with precarious immigration status in their community or institution, the constraints that they face can result in compounding feelings of emotional distress. This sense of obligation, combined with the feeling of not being able to do enough as individuals due to institutional and broader structural constraints, can lead to frustration and heightened distress (Lo & Nguyen, 2021).

Racialized women continue to bear the brunt of advocacy and unpaid care work disproportionally, shaped by intersecting racialized, patriarchal and gendered inequalities (Collins, 2015; 2000; Crenshaw, 1990). Many participants expressed a sense of wanting to do more while feeling low on energy, particularly those in caring and support roles. Sofia, who works as a dietician at a government organization, reflected on the loss of a program she had been involved in that provided services to marginalized pregnant people, which was cut during the COVID pandemic, stating: "I am the only Spanish speaking person…the staff having diverse background (it's) important, but, yeah, I've been thinking that I should advocate, I should say something, but I don't know, I guess maybe I'm getting old and, yeah, I should have done something." Her reflection illustrates how the emotional demands of advocacy work can at times feel overwhelming and cause activists to withdraw from their efforts. These emotional demands are not evenly distributed. Gendered and patriarchal expectations shape who takes on this work (Lorde, 1984), and institutional roles (discussed in the next section) further compound these pressures, contributing to distress and burnout.

"We can't always help in the way that we want:" Institutional Impacts on Emotional Distress

The institutional context within which street-level actors work also intertwines with these intersectional challenges and impacts their feelings of emotional distress. Much of the health literature shows that emotional distress is high across all roles in healthcare settings, with nurses reporting the highest levels of distress compared to physicians and others working as indirect caregivers, such as those in administrative roles (Houston et al., 2013; Whitehead et al., 2015). Emotional distress in institutional and organizational settings is linked to low job satisfaction and engagement, and negative workplace environments, such as a lack of support from coworkers or management when navigating difficult situations with those they support (Lamiani et al., 2017). Furthermore, limited capacity for advocacy and a feeling of limited empowerment to engage in autonomous advocacy intensify this distress in institutional and organizational settings (Lamiani et al., 2017).

Women traditionally take on paid and unpaid care work in healthcare and social movement spaces, including behind-the-scenes advocacy work that goes unnoticed (Márquez, 2021). In institutional settings, such as hospitals, women often handle administrative tasks (Alasoadura, 2020). These positions are limited in their training, time, resources, capacity, and flexibility for advocacy (Alasoadura, 2020). People in front-line roles, such as administrative workers, experience greater overall precarity, including less pay and training, than doctors (Amreta et al., 2020; Dzeng & Wachter, 2020). These factors contribute to higher levels of distress (Amreta et al., 2020; Dzeng & Wachter, 2020). At the same time, administrative staff often hold responsibility for much of the initial gatekeeping in institutions and the enforcement of healthcare boundaries. As a result, they are frequently placed in conflicting positions, tasked with enforcing healthcare borders and upholding policies that restrict access, while also occupying supportive, caring-oriented roles as healthcare workers.

As discussed in Chapter 5, when activists' personal stories of deservingness differ from those embedded in their institution, this can limit their capacity to advocate within their workplace. In these situations, activists often expand their networks outside of their institutional context. These external spaces better support the activists' stories of deservingness and guide them in prioritizing and supporting individuals in securing healthcare access.

When facing institutional barriers, such as funding limitations, activists may be forced to reproduce familiar stories of deservingness, portraying some migrants as particularly vulnerable or worthy to justify their access to care. Although Canada claims to provide universal healthcare for all, systemic processes like privatization and restrictive laws and policies create significant gaps in the healthcare system. As a result, street-level actors often work with limited resources, compelling them to make complex, discretionary decisions about allocating funds and delivering care and having to draw on and reinforce these dominant discourses.

These constraints give rise to moral and ethical dilemmas, as providers have to make difficult decisions about allocating care within tight budgetary limits. Anne, a doctor in a clinic, described her previous work in an organization where the budget allocated approximately $500 per patient for all types of care, including imaging, diagnostic tests, and specialist services. This financial limitation made allocating resources effectively and meeting all patients' needs difficult. This made her ask questions like: "What if this person needs to go in to see a specialist, or they need that ultrasound, do I really need [to give] this blood test?" Anne, who had experience working both with refugee and non-status clients, noted that these questions did not arise while working with refugee clients (since IFH covers refugee claimants). However, in a community setting supporting non-status individuals, limited resources made providing care beyond these restricted budgets impossible. Anne expressed frustration, noting that these limitations meant she was often "compelled to practice in a different way."

For many participants, an important aspect of their advocacy was their deeply held beliefs about social justice issues, human rights, and ethics of care. In situations where they were limited or unable to act, participants, like Anne, not only had to draw on familiar stories, but often did so with ambivalence. For instance, Anne joined broader advocacy and acted in solidarity with migrant justice organizations, expressing the belief that everyone deserves healthcare. This ambivalence sometimes motivated participants to act by engaging in creative strategizing and building relationships, such as joining broader mobilizations. In this way, these ambivalent stories and feelings associated with them shape de/bordering strategies in situational and emotional ways. While the actions they take to resolve this ambivalence are not always large-scale, they still constitute a form of resistance from below, working within conditions of constraint (Scott, 1985).

This sense of "not being able to help in the way we want" (Layla, Doctor, CHC) and being compelled to practice "in a different way" (Anne, Doctor, Clinic) was a shared experience among participants who provided direct care. Street-level actors act as gatekeepers to healthcare access, and they often face a tension between the care and support they can provide and what they wish to offer. The necessity to prioritize care based on available funding led to emotional distress for participants. As Bitheny, an administrative worker in a hospital, puts it: "A lot of times [we] try to provide the best care… I don't wanna say at the lowest cost, but just trying to make it easier, I guess I'm gonna say, on the person."

However, this also speaks to the broader systemic failures of the Canadian healthcare system, where social services and support—including access to affordable, comprehensive healthcare, clear pathways for navigating the system, and adequate training for street-level actors on issues faced by individuals living with precarious immigration status face—are often insufficient. As a result, community organizations and activists often shoulder the responsibility of providing healthcare. Limited institutional resources, such as funding, staffing, and infrastructure, exacerbate care gaps, and force street-level actors to make challenging discretionary decisions about whom to prioritize and under what circumstances. These constraints reflect broader systemic issues within healthcare, contributing to health inequities and shaping processes of differential inclusion.

Activists' Strategies to Negotiate Care and Reduce Distress - Role of Broader Advocacy

In response to these intersectional and institutional challenges producing distress, I have outlined in storytelling (Chapter 5), creative strategizing (Chapter 6), and coalition-building (Chapter 7), the strategies activists use to navigate these conditions and challenge structural inequities. While all of these approaches contribute to managing the emotional burdens of advocacy work, I emphasize coalition-building as particularly important in managing distress and feelings of ambivalence. I outline some examples of the challenges faced by activists as they navigate institutional barriers and develop workarounds, followed by coalition-building strategies. Here and elsewhere, however, I note the limitations of this ad-hoc and informal strategizing. Coalition work helps activists collectively confront structural barriers, reducing a sense of isolation and individual responsibility.

In terms of utilizing informal, creative de/bordering, participants in organizations with limited funding employed various strategies to access resources for individuals with precarious immigration status. These included creating financially feasible care plans for patients, using compassionate funding, and building relationships to gather medical care supplies. For instance, providing care at a lower cost to the institution, as Bitheny describes, highlights the systemic inequities that emerge when healthcare rights are allocated based on discretionary assessments of deservingness.

While some participants used these creative strategies to negotiate low-cost care options for individuals with precarious immigration status, these efforts often resulted in inadequate care. Canada's healthcare system fails to provide accessible, affordable, or comprehensive healthcare for those with precarious immigration status, often denying them the right to care. This systemic exclusion leads to gaps in care, sub-standard treatment, and, at times, the outright denial of services. These exclusions do more than limit access, they also shape how individuals with precarious immigration status are perceived within institutional cultures by individual providers. Often, they are viewed as less "deserving" of care compared to those with citizenship or permanent residence (Chen, 2017; Caulford & D'Andrade, 2012; Gagnon et al., 2021; Goldenburg et al., 2023). As Sage, a doctor in a hospital, describes:

> It's just it's honestly so heartbreaking what people live with… the fear of not being able to access healthcare if they need, but also having active issues that they're just letting deteriorate because they don't feel they have any other choice…just living with whatever pain they have, whatever mental health crisis situation, cause they don't feel like they're entitled to healthcare, which is awful…I remember sending somebody for cancer care and when they got there they were still told no…It's a system that is predominantly designed, *not* with this population in mind…the system is designed to view that person with suspicion, and is designed to deny them care in many ways…the *almost* universal healthcare system makes it really, really hard for the people that don't have access to it.

As Sage explains, the absence of a truly universal healthcare system, one that provides substantive access to care, results in inadequate treatment for marginalized groups, including those with precarious immigration status. Exclusionary im/migration and health laws and policies permeate all levels of care. This reinforces a specific notion of deservingness tied to perceived need, vulnerability, and/or economic contribution, perpetuating health inequities for

with precarious immigration status. Street-level actors often make choices that, while not aligning with their beliefs and values, are shaped by institutional and structural constraints, contributing to their emotional distress.

Participants also faced barriers related to institutional finances, such as challenges in accessing affordable medication for their clients. For instance, Mateo discussed medications with his patients with precarious immigration status, and sometimes decided to opt for more affordable alternatives that might not be the best option for their condition. He similarly described providing such care as "heartbreaking," feeling compelled to find workarounds despite knowing these solutions were less than ideal.

To address these financial barriers, participants used de/bordering strategies, such as applying for funding to cover the cost of individual cases as needs arose. Vivian spoke about these ad-hoc funding arrangements as important but also noted that it was unfortunate that funding is found only "through this very word of mouth underground, patchwork of programs that have intermittent sparse funding for a bracketed amount of time."

For those assisting people facing compounded issues, such as living with precarious status while being without housing and, in addition, having a palliative diagnosis, it could be extremely challenging to negotiate access to care. There is limited funding available, even when participants actively reach out to apply for compassionate funding. Poppy, a palliative care nurse working at a community organization, described the severe limitations faced by a patient who was unhoused and had a palliative diagnosis, highlighting the frustration of trying to provide care with minimal support and resources:

> [For people who have precarious status], they literally have nothing. There's no home care, no OT, no equipment, no medications. I'm caring for a client right now who has nothing. We're paying for all his medications. I've had to reach out to different hospices to see if they will provide a compassionate admission for him when it comes to end of life for him. But there's no nursing that will go in to see him. And he's staying outside of the city now because he's staying with his sister. So, there's literally no one else to help him other than our team…that is the most frustrating – how can anybody let anyone else die like that? Do nothing, with no medication, with no support. Ah, it breaks my heart.

Poppy's description of the experience as "breaking her heart" reinforces a recurrent theme in this chapter, how participants use language like "heartbreaking" to articulate the emotional distress that arises when witnessing systemic injustice and feeling unable to intervene.

Despite experiencing emotional distress, many participants continued to engage in acts of de/bordering because these actions allowed them to feel connected to a collective effort to challenge broader systemic health inequities. This highlights a potential paradox in social movement work: advocacy fosters solidarity, helps manage emotional distress, and contributes to that distress. Witnessing the suffering of those they assist can intensify activists' distress. However, such constraints can also generate ambivalence and spur action. For example, in Poppy's case, facing institutional barriers led her to work with others to de/border. More broadly, participants engaged in similar iterative and creative de/bordering strategies in response to multi-level, shifting institutional, interpersonal, and emotional contexts.

Poppy's feelings of frustration and anger stemmed from witnessing the unmet needs of her patients and feeling unequipped to meet them fully, an emotion expressed by others. Poppy describes this tension of needing to do more but not being able to do so, saying: "How do you say no to somebody that needs help, and you're the only team that is doing what they need?" This sense of moral/ethical obligation motivated her to address gaps in care and gather supplies not covered by home care. She described having an entire garage filled with wound care supplies and wheelchairs. Many of these supplies came from other activists, with Poppy referring to this network as an "underground culture of goodwill." This "underground patchwork" network is often motivated by a sense of deservingness rooted in humanitarianism. Specific gaps – such as the lack of palliative care supplies, prompted Poppy and others to collaborate in order to meet the perceived needs of individuals with precarious immigration status, facing complex, chronic, and palliative conditions.

Involvement in solidarity and coalition-building movements helped activists cope with feelings of emotional distress, while also allowing them to engage in broader advocacy to challenge systemic inequities to healthcare access. Activists used various forms of community advocacy and support networks as outlets to address and mitigate these feelings. Participation in committees, networks, groups, and organizations outside their daily work helped many

participants feel connected to broader efforts, where the systemic issues they encountered while negotiating care could also be addressed.

Participants used advocacy work outside their day-to-day responsibilities to deal with the emotional distress arising from their everyday roles and vice versa. Knowing they were not alone in tackling health inequities or facing systemic barriers provides solace. Carmine, a doctor in a hospital, balances clinical work and health justice advocacy and found that when advocacy moves very slowly and becomes frustrating, he looks towards his clinical work to bring about a sense of satisfaction. His day-to-day work offers more instant gratification, and he can focus on the "wins that [he was] getting with [his] patients." However, he also noted that clinic work can also be frustrating because of "the limits of our social services; the limits of who our healthcare system covers and doesn't." For Carmine, the realization that he can only do so much for patients, being constrained by larger, broader issues of a lack of social services and healthcare entitlements, created a feeling of emotional distress. He found that advocacy work served as an outlet for addressing broader structural issues, such as the lack of access to services and entitlements.

Some research in social movement studies has explored how the emotional dimensions of street-level actors' day-to-day work intersect with broader advocacy efforts, particularly from the perspective of individual experiences (Goodwin & Jasper, 2001; Jasper, 1998). This dissertation seeks to contribute to this underdeveloped area by examining the roles of individual street-level actors, particularly their emotional, relational, and temporal experiences, in conducting advocacy work. For Carmine, interactions across various moments in time, environments, and individuals shaped his affective experiences and emotional responses. This demonstrates that he viewed his clinic work and advocacy as mutually informing and reinforcing each other. Participants felt that advocacy enhanced their work in both areas and helped them remain "energized" (Carmine, Doctor, Hospital). For Carmine, this sense of being energized came from recognizing his advocacy work and clinical practice as contributions to an effort addressing systemic inequities. Connecting with a broader community that shared a common purpose was discussed by Carmine – and by others, such as Hope (discussed below), as a way to manage their emotional distress and reinforce their commitment to the work.

Some participants' activist work experience highlighted their principles and values during difficult situations in their practice, shaping their affective responses and allowing them to "turn towards" those they are assisting (Ahmed, 2014). This relational process of "turning towards" involves attributing value to the object or person focused upon, a valuing that Ahmed (2014) explains occurs through emotional resonance, often shaped by normative or dominant frameworks. In this way, emotions can reinforce power relations but can also serve as tools to challenge systems of power (Hunter, 2021). As Ahmed (2014) notes "it is through emotions, or how we respond to objects and others, that surfaces or boundaries are made: the 'I' and the 'we' are shaped by, and even take the shape of, contact with others" (p. 10).

For participants, this emotional engagement in broader advocacy, particularly when confronting structural inequities, helped shift people from a sense of passive empathy or powerlessness, contributing to distress, to a deeper feeling of standing with those impacted and confronting systemic issues directly. Ahmed (2014) captures this dynamic:

> "The call of such pain, as a pain that cannot be shared through empathy, is a call not just for an attentive hearing, but for a different kind of inhabitance. It is a call for action, and a demand for collective politics, as a politics based not on the possibility that we might be reconciled, but on learning to live with the impossibility of reconciliation, or learning that we live with and beside each other, and yet we are not as one" (p. 39).

Similarly, Hope's experience of integrating her activist principles into her midwifery practice illustrates both the feelings of personal failure and distress that can arise in activist work, and how these emotions are managed through relational de/bordering work grounded in challenging structural inequities and fostering social justice:

> I think then because of [the activist work I do], I lean on those principles in my life and work. If people come from backgrounds that have had less exposure to those…clear activist principles, we can sometimes get caught in the trap of compromising baseline principles for logistical arguments or bureaucratic arguments…In practice, we're dealing with those convoluted details [logistical and bureaucratic arguments], but for me, it is grounding to be able to lean on these basic activist principles that center the people rather than getting into the mishmash of trying to think bureaucratically, or justifying decision-making on the mix of the details rather than just relying on the basic principles of justice.

While advocacy work contributes to stress and distress for participants, it also provides a sense of community, solidarity, and self-empowerment, and a way to engage with their values, often to secure healthcare and challenge systemic inequities. For Sol, as mentioned earlier, her broader advocacy work allowed her to question ideas of power. Who can determine life-changing decisions, such as who gets to live and remain in a country? As Sol mentioned, being involved in this broader activism allowed her to take back some of this power by working towards tackling systemic barriers and making a change for the patients with whom she works:

> [Broader advocacy work] helps me feel like I have some power to make change because it can be very frustrating to listen to the stories that people share and then say there's not much I can do… I can give you strategies, but my hands are tied when it comes to actually making change. So, [advocacy work] at least makes me feel like I'm making some sort of difference systematically

Participants' experiences reveal the tension between paid work and advocacy. At various moments when people were already experiencing burnout, the notion of taking on advocacy work did not seem possible. However, at other moments, participants viewed their advocacy work as a strategy to manage emotional distress.

Accounts like Sol's show that emotional responses to systemic injustices do not always lead to disengaging from advocacy altogether. Instead, they can prompt activists to shift how they view their work, adjust their strategies, and redefine their advocacy priorities. This iterative process illustrates how de/bordering strategies, shaped by interpretations of deservingness – are continuously reworked through sustained engagement, influenced by shifting emotional, interpersonal, and institutional contexts.

Discussion and Conclusion

While Chapters 5 through 7 examined how activists understand and perform de/bordering work, this chapter narrows in on how they emotionally experience and respond to this work. It addresses the research question: how do activists manage the emotional challenges associated with their work? To answer this, I explored how institutional context and activists' intersectional positionalities, particularly in relation to gender, race, and immigration status, shape their experiences of emotional distress shape participants' experiences of emotional distress.

Emotional distress often emerged when participants felt ambivalent: when their values (humanitarian/solidarity, etc.) conflicted with institutional expectations or when they were constrained in what they could do to support, especially when there is a dissonance between the stories of deservingness they hold and those embedded in their workplace.

Health studies literature has established that framing issues as shared rather than personal can reduce discouragement and improve activists' capacity to tackle emotional challenges (Olcoń & Gulbas, 2021). Consistent with this, this chapter shows that engagement in broader advocacy, coalition-building, and fostering connection helps activists manage distress and collaboratively disrupt systemic health inequities.

Drawing on existing literature and my interview data, I argue that while engaging in advocacy contributes to emotional distress, the relational aspects of coalition-building, such as fostering connection, not only help reduce that distress but also enable activists to feel less isolated in challenging systemic barriers to healthcare access.

The social and relational aspects of coalition-building strategies provided participants with emotional support, connections, and practical strategies to navigate systemic exclusions. These networks also enabled participants to reframe their emotional experiences not as personal failings but as shared consequences of structural injustice. In doing so, it also allowed participants to rework the stories of deservingness that them tell themselves and others. These stories are not fixed; they are continuously and creatively re/shaped and re/worked through emotional and contextual experiences.

These findings extend this dissertation's broader argument that deservingness is a dynamic, non-binary, and multi-dimensional process. Emotional distress not only drives activists to seek out coalition-building as a social and relational form of de/bordering that helps manage distress and isolation, it also enables them to reframe deservingness in creative and strategic ways. Thus, activists' de/bordering work reflects a dynamic approach to deservingness—one that is relational, contextual, and iterative. This chapter contributes to bordering and migrant health advocacy scholarship by highlighting the emotional, relational, and social dimensions of de/bordering. While advocacy work can generate distress, this chapter demonstrates that activists engage in de/bordering and contribute to dynamic strategies of differential inclusion – through

storytelling, creative negotiation, and coalition-building, to negotiate access and challenge structural healthcare inequities. Among these, coalition-building plays a particularly important role in helping activists sustain their advocacy in the face of emotional distress and systemic inequities.

Chapter 9: Conclusion

I began this dissertation with a story about a little boy and a doctor who recognized that healthcare access can mean the difference between life and death. Dr. Suleman's account reminds us of the emotional, real-world stakes that frame this dissertation and why activists continue to fight for change despite institutional and structural constraints. As participants described, the systems they navigate are constrained, restricted, and often discretionary. Decisions about negotiating healthcare access, assessing deservingness, and working within or against structural barriers are complex, emotional, and sometimes paradoxical. Within these informal patchworks of access, this messiness reflects the lived realities under which activists work. It also highlights their creative strategizing, storytelling, and relationship-building as ways to navigate structural and institutional constraints.

This dissertation set out to answer my central research question: how do migrant health activists in Ontario negotiate healthcare access for individuals with precarious immigration status through emotional de/bordering work, and how does engaging in this work affect them? Drawing on interviews with 47 migrant health activists and analysis of governmental and institutional health documents, I addressed three sub-questions: (1) how activists' strategies evolve in response to structural and emotional barriers; (2) what tools and supports are necessary for effective work; and (3) how activists manage the emotional demands—including distress—generated through advocacy.

My findings show that activists' storytelling and emotional responses—such as frustration, compassion, and anger—are not peripheral, but central to how activists navigate exclusionary institutional and structural contexts (Chapter 5). Activists' informal strategies like calling in favours or appealing to sympathetic providers (Chapter 6) reveal how this emotional work is embedded in everyday advocacy. While these strategies often facilitate access, they can simultaneously reproduce familiar, dominant stories of deservingness. Relationships, coalition-building, and fostering solidarity (Chapters 7 and 8) are key ways that activists manage their emotional distress while also challenging the structural constraints that contribute to their distress, which can sustain their advocacy over time.

In line with the three contributions outlined in Chapter 1, this dissertation first reveals that emotional de/bordering work is central to how activists navigate and challenge exclusionary healthcare systems. By drawing together social movement literatures and feminist affect theory, I bring focus to the important role of emotional, contextual, and narrative dimensions of activists' practice. This interdisciplinary, multi-level approach is grounded in feminist orientations, integrating insights from feminist affect and social movement scholarship, expanding the bordering literature by moving beyond binary conceptualizations of deservingness and urging scholars to further account for the situational, emotional and often (in)visible work in which activists engage. Second, I contribute to new ways of understanding deservingness as multi-dimensional and non-binary, emerging contextually and emotionally through activists' storytelling, negotiations, and personal experiences. This dynamic understanding challenges the rigid "deserving/undeserving" dichotomy prevalent in bordering literature, instead, offering a perspective that can account for activists' interpersonal, institutional, and emotional contexts, and the ways they contribute to processes of differential inclusion through inclusionary de/bordering. Third, I contribute to bordering scholarship by offering a new way of examining emotional distress in migrant health advocacy. I show the relational and social aspects of activists' de/bordering work in managing distress, as they challenge structural inequities in healthcare. This perspective reveals that although advocacy work can cause emotional distress when conflicting stories of deservingness emerge, it also promotes community, solidarity, empowerment, and a connection to one's values.

A potential benefit of my involvement in migrant health advocacy is that it provided deeper insight into the issues and strategies than might otherwise have been possible otherwise. However, this involvement may also shape how I interpret the findings. For instance, my familiarity and involvement in the PHSUP cuts advocacy helped me recognize that activists were holding these ambivalent perspectives, as I listened and participated in these spaces. Additionally, my background in nursing influenced my focus on the emotional dimensions of activists' work, leading me to pay closer attention to how distress and care shape praxis. While I aim to approach this research reflexively, I recognize that my orientation towards a social justice, equity lens and my positionality as a white, woman, researcher influenced what I paid attention to, which stories I considered as meaningful, and what I saw as priorities for analysis (Summers Effler, 2010).

Additionally, while my research focused solely on activists' perspectives, future work could benefit from including street-level actors, both those involved in advocacy and those who are not. This would offer valuable insights into how assessments of deservingness are conceptualized across diverse contexts – by a range of actors, through varied stories, and with differing emotional experiences. Applying the lens of emotional de/bordering work adds an under-represented dimension to current scholarship on the topic of migrant health activism, informing both the sustainability of individual and collective movements and the complexities of health advocacy for individuals with precarious immigration status. While primarily contributing to scholarly debates, this research also offers insights to inform activists' praxis by highlighting the central role of emotional de/bordering work in negotiating healthcare access and challenging structural inequities.

At its core, this dissertation calls for greater attention to the complexity of migrant health activism as a dynamic, iterative process—one that existing bordering frameworks struggle to fully capture. By centering emotion, context, and storytelling, it offers a multi-dimensional understanding of deservingness. Activists' stories do more than respond to exclusion; they imagine and enact alternative futures despite constraints. Attending to the nuance of their emotional de/bordering work enriches bordering scholarship. It highlights the centrality of activists' storytelling, creative negotiation strategies, and relationship-building work, and underscores their ongoing struggle for an equitable, inclusive healthcare system.

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Appendix A: Distress Word Dictionary - All Iterations of Lexical Search of Distress-Related Words

aggravate-, anxi-, awful-, barrier-, blame-, bother-, “burn out”, “burned out”, challenge-, complex-, concern-, confus-, crazy, decid-, depress-, difficult-, disappoint-, distress-, emotion-, empath-, exhaust-, fair-, feel-, felt, frustrate-, fuck-, “hands are tied”, hard, harmful, heartbreak-, help-, horribl-, hurt-, inability, limit-, lone-, meaning-, moral, “moral distress”, numb-, overwork-, problem-, rundown, overwork-, sad-, scar-, stress-, struggle-, tens-, terribl-, tortur-, tough-, trauma-, unable, uncomfort-, undeserve-, unfair-, upset-, worr-

Appendix B: A Table of Distress Frequency Calculations and Exploratory Analyses: Cross-Tabulation of Emotional Distress by Institution and Role

Distress-Related Word Use Frequency Calculation

Document Name	Interview Word Count	# Distress-Signalling Words Used	Distress Word Use Frequency (%)	Institution	Role
1[34]	4943	16	0.3237	Hospital	Doctor
2-	6625	29	0.4377	Community Legal Clinic	Lawyer
3	5356	27	0.5041	Hospital	Doctor
4	3202	13	0.4060	Hospital	Doctor
5	2752	10	0.3634	Hospital	Doctor
6	6804	13	0.1911	Migrant Rights Network	Organizer
7	2345	17	0.7249	CHC	Doctor
8	2692	16	0.5944	Clinic	Nurse
9	6162	20	0.3246	Clinic	Nurse
10	2172	13	0.5985	Clinic	Nurse
11	6092	20	0.3283	Clinic	Doctor
12	3267	16	0.4897	CHC	Social Worker
13	3309	18	0.5440	Hospital	Doctor
14	3863	17	0.4401	CHC	Doctor
15	2535	5	0.1972	Hospital	Doctor
16	6468	20	0.3092	Government Organization	Dietician
17	2379	21	0.8827	Hospital	Social Worker
18	3723	17	0.4566	Hospital	Doctor
19	6746	17	0.2520	Clinic	Administrative Worker
20	6208	17	0.2738	Migrant Rights Network	Administrative Worker
21	2531	10	0.3951	Government Organization	Researcher
22	5365	21	0.3914	Clinic	Nurse
23	7329	20	0.2729	Community Legal Clinic	Social Worker
24	3693	6	0.1625	CHC	Community Health Worker
25	4092	10	0.2444	CHC	Administrative Worker
26	3207	19	0.5925	CHC	Doctor
27	6380	28	0.4389	CHC	Social Worker
28-	2098	1	0.0477	CLC	Lawyer
30-	6037	23	0.3810	Migrant Rights Network	Organizer
31	4268	12	0.2812	Hospital	Doctor
32	3917	11	0.2808	Migrant Rights Network	Organizer

[34] Distress word use frequency was assessed in 43 of 47 participant interviews. 4 of the interviews were excluded from this analysis because they were not transcribed.

33	1210	8	0.6612	CHC	Dietician
34	5389	22	0.4082	Clinic	Midwife
36	3996	13	0.3253	CHC	Administrative Worker
37	7717	14	0.1814	Religious Institution	Administrative Worker
40	6661	23	0.3453	Clinic	Nurse
41	5621	24	0.4270	Clinic	Nurse
42	2105	10	0.4751	Hospital	Administrative Worker
43	2273	10	0.4399	Hospital	Administrative Worker
44	1182	4	0.3384	Migrant Rights Network	Administrative Worker
45-	3590	15	0.4178	Clinic	Doctor
46	3933	15	0.3814	Clinic	Midwife
47	2581	13	0.5037	Clinic	Management

As part of the exploratory phase of this project, I initially conducted a cross-tabulation analysis of the frequency of emotional distress-signaling word use as a function of participants' institutional affiliations (e.g., CHCs, hospitals) and workplace roles (e.g., doctors, administrators, support staff). This approach aimed to assess whether patterns of emotional distress varied by institutional context or professional role.

The number of participants within each subgroup, however, was too small to support meaningful comparison or generalizable claims. Given this constraint, and because institutional role and workplace did not appear to be significant determinants of reported emotional distress, I opted not to pursue this analytic pathway in the final dissertation. Instead, I focused on analyzing the normalized frequency of distress-signaling word use across individual interviews, allowing for greater attention to the situated and narrative dimensions of distress, rather than categorization by institutional or professional groupings.

Distress-Related Word Use Frequency by Institution: Sum of Squares (SS), Degrees of Freedom (df), Mean Squared Error (MS), F Value, (F), P-Value, F-Crit

Anova: Single Factor – Analysis of Variants						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Hospital	11	4.87388917	0.44308083	0.03170438		
Community Legal Centre	3	0.75828882	0.25276294	0.03834271		
Migrant Rights Network	5	1.46512486	0.29302497	0.00517735		
Community Health Centre	9	4.07942177	0.45326909	0.03533494		
Clinic	12	4.97257588	0.41438132	0.01115583		
Government Organization	2	0.70431535	0.35215767	0.00368822		
Religious Institution	1	0.18141765	0.18141765	0		
	0	0	0	0		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	0.22241345	7	0.03177335	1.35038207	0.25688175	2.28523517
Within Groups	0.82352044	35	0.02352916			
Total	1.04593388	42				

Distress-Related Word Use Frequency by Role: Sum of Squares (SS), Degrees of Freedom (df), Mean Squared Error (MS), F Value, (F), P-Value, F-Crit

Anova: Single Factor– Analysis of Variants						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Doctor	13	5.57975864	0.429212203	0.0196506		
Lawyer	2	0.48540029	0.242700146	0.07607785		
Organizer	3	0.85287518	0.284291725	0.00902639		
Nurse	6	2.68113999	0.446856664	0.01469926		
Social Worker	4	2.08422978	0.521057444	0.06670844		
Dietician	2	0.97037162	0.48518581	0.06193174		
Administrative Worker	8	2.53037971	0.316297463	0.01005235		
Researcher	1	0.39510075	0.395100751	0		
Community Health Worker	1	0.16246954	0.162469537	0		
Midwife	2	0.78962726	0.394813629	0.00036048		
Management	1	0.50368074	0.503680744	0		
ANOVA						
Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	0.30971569	10	0.030971569	1.34619084	0.24927397	2.14248784
Within Groups	0.7362182	32	0.023006819			
Total	1.04593388	42				

Appendix C: De/Bordering Strategies Impacts, and Challenges

Context	Area of De/bordering	Process of De/bordering	Individual and Collective Strategies	Impact of De/bordering	De/bordering challenges	Strategies to address challenges
Within Institutions	Institutional Change	Creating awareness within institutions on needs of migrants	Training and webinars, advocating for internal policy change	Knowledge sharing. Reforming policy	Limited power as an individual within institution	Expanding networks and coalitions for broader support
	Informal Advocacy	Providing case-by-case advocacy for individuals with precarious immigration status	Warm hand-offs, negotiating care, accompanying patients to appointments, providing resources for self-advocacy	Securing healthcare access for individuals with precarious immigration status	Resource and time limitations, risk to professional standing. Often need to frame issues using familiar stories of deservingness	Building networks and support systems for collaboration
	Community-Based Health Initiatives	Outreach to individuals with precarious immigration status in community settings	Peer ambassadors, vaccine clinics, mobile health buses, handing out flyers, community-building through events (soccer tournaments, potlucks)	Expanded access to care (e.g., reaching those in geographically isolated areas. Building trust and fostering community	Reliance on volunteer work, capacity and resource limitations	Creative strategizing, (e.g., adjusted clinic hours, targeting community hubs like grocery stores, leveraging external networks
Broader Advocacy	Activist Coalition-Building	Organizing and mobilizing advocacy events, building and retaining networks	Organizing rallies, sit ins, door-knocking/postering, recruiting for the movement, creating new networks	Challenging restrictive healthcare. Increased membership in movement	Having to appeal to broader public/government; internal movements tensions	Reflexive advocacy, creative strategizing, and involvement from directly affected, individuals
	Policy/ Legal Advocacy	Advocating for inclusive health policies – (e.g., PHSUP re-instatement, health for all)	Writing policy briefs/ letters to MPs, placing pressure on policymakers	Potential policy reforms (e.g., healthcare access for all residents)	[35]Need to frame issues using familiar stories	[36]Diversifying advocacy approaches

[35] Limited capacity, resources and time for advocacy work is a common challenge across all contexts/areas of de/bordering.

[36] Coalition-building and leveraging external networks are core strategies for addressing de/bordering challenges and increasing the efficacy of advocacy efforts across all contexts/areas of de/bordering.

Appendix D: List of Hospital Fees in Selected Ontario Hospitals (as of December 2023)

Hospital	Area	In-patient/Out-patient	Uninsured/Non-resident Fees	Insured Fees
St. Josephs Health Centre	GTA	In-patient	Required to make a deposit for the estimated length of stay. Meet with Patient Accounts Department to discuss payment plan if unable to pay in full. Paying upfront preferred.	Covered
		Outpatient	Required to pay at time of service. Make arrangements with Patient Accounts Department and required to sign Outpatient Responsibility for Payment and Authorization to Release Information Form	Covered
Scarborough Health Network	GTA	In-patient	"Uninsured and Out-Of-Country" Standard ward: $2800 Newborn: $1650 Intensive care: $7814 Deposit required prior to service delivery. Uninsured patients will also receive a separate bill for physician's care. Will be required to pay all estimated fees in advance.	Covered
		Outpatient	Ambulance: $240 Emergency visit: $720 Outpatient clinic: $430 Dialysis: $992 Lab: $180 Diagnostic Imaging test clinic: $430 +2 times OHIP rate	Covered
William Osler Health System	GTA	Emergency in-patient	Acute care-standard ward: $3700 Acute care-Newborn: $1500 Rehab/Chronic-standard ward: $3700 Intensive care unit/neo-natal intensive care unit: $6000 Pre-payment of charges for uninsured patient required. Request deposit for three days of inpatient stay. Acute or rehab Semi-private: $3890 Acute or rehab private: $4010 Chronic-semi-private: $3980 Chronic-private: $4010 Overnight hospital stay standard ward: $2000	Covered by OHIP for acute, rehab, intensive. Acute or rehab Semi-private: $280 Acute or rehab private: $310 Chronic-semi-private: $45 Chronic-private: $65
	GTA	Emergency outpatient	ER visit: $1000 Outpatient clinic visit: $600 Chemo: $600 Minor procedure: $400 Chiropody: $600 Dialysis: $1400 Ambulance: $240 Fees listed only for basic assessment. Cost can be higher due to high-cost diagnostic procedures, consult fees, physician fees	Covered by OHIP mostly Chiropody: $20 Ambulance: $45
	GTA	Surgery	General anesthesia (first 60 mins, billed in 30 min. Blocks): $1500 General anesthesia subsequent (30 min block): $500 Local anesthesia (first 30 mins): $310 Local anesthesia (additional 30 mins blocks: $110 Local anesthesia with IV sedation (first 30 minutes): $410	Covered

			Local anesthesia with IV sedation (additional 30-minute blocks): $160 Fees exclude the uninsured daily inpatient room rate, physician fee and cost of implants, if relevant.	
	GTA	Diagnostic Imaging	X-ray: $100 Each additional x-ray: $50 MRI: $800 MRI with gadolinium: $875 Ultrasound: $175 Each additional ultrasound: $100 CT Scan: $550 CT scan with contrast: $600	Covered
	GTA	Cardiac procedures	Cardiac angiogram: $2500 Cardiac catheterization/angioplasty: $4800 Percutaneous coronary intervention (PCI): $7300 None of the above include outpatient clinic fee	Covered
	GTA	Obstetric fee	Rhogam injection (usually one per pregnancy): $150 Cord blood collection fee (private): $150 Neither cover outpatient clinic fee	Covered
		GI	Endoscopy-single: $250 Endo gastro and colonoscopy: $350 Neither cover outpatient clinic fee	Covered
Queensway Carleton Hospital	Ottawa	Impatient	Room Charges per day: Ward room - Regular Uninsured resident of Canada $964 Non-resident of Canada $2990 Ward - Intensive Care Uninsured resident of Canada $4049 Non-resident of Canada $6000 Semi-private room Uninsured resident of Canada $1184 Non-resident of Canada $3,210 Private Room Uninsured resident of Canada $1224 Non-resident of Canada $3250 All of the above fees are in addition to fees billed by physicians	
		Outpatient/Emerg	Uninsured resident: $302 Non-resident of Canada: $930	
		Day surgery	Uninsured/Non-resident: Low: $850 Medium: $3126 High: $13160	
		Diagnostic Imaging	X-Ray, varied (plus Hospital visit fee) Uninsured resident of Canada $33 and up Non-resident of Canada $49 and up MRI per time block (plus Hospital visit fee) Uninsured resident of Canada $480 Non-resident of Canada $2030 CT Scan (plus Hospital visit fee) Uninsured resident of Canada $599 Non-resident of Canada $2130 High Risk Ultrasound (plus Hospital visit fee) Uninsured resident of Canada $302 Non-resident of Canada $359 Lab Tests, each (plus Hospital visit fee) Uninsured resident of Canada $128 Non-resident of Canada $360	
		Obstetric fee	Room & Care Charges for baby per day (in addition inpatient charges for mother): Ward for Baby per day: Uninsured Resident of Canada $919 Non-resident of Canada $2475	

			Intensive Care for baby per day: Uninsured Resident of Canada $4049 Non-resident of Canada $6000 Circumcision: Uninsured Resident of Canada $350 Non-resident of Canada $500 Lab Tests, each: Uninsured Resident of Canada $128 Non-resident of Canada $360	
Sunnybrook	GTA	Emergency room	Non-resident rate: $800 Uninsured: $400	
		Daily ward	Non-resident rate: $3700 Uninsured: $1720	
		Intensive care	Non-resident rate: $5560 Uninsured: $3600	
Halton Healthcare	Halton	Inpatient	Standard ward: $2800 Newborn: $1600 Intensive care: $4200 Close observation (in hospital): $3500 Special care nursery: $2400 Uninsured patients may be required to place a refundable deposit with the hospital prior to service delivery. All will also receive a separate bill for physician care.	Covered except for semi/private, patient transport, and per diem surcharge $400
		Outpatient fees	Emerg visit $700 + $200 physician fee Outpatient clinic: $700 + possible $200 Dialysis clinic: $1100	
Niagara Health	Niagara	Inpatient	Includes hospital fee only. Physician fees will. Be billed separately. Acute care in ward: Non-resident (no Canadian citizenship or PR card): $3100, uninsured (no valid OHIP card): $1350 Acute-ICU/CCU: Non-resident: $4050, Uninsured: $2025 Nursery: non-R: $1700, uninsured: $845	Charged for semi/private
		Outpatient fees	Emergency or clinic visit: Non-resident: $720, Uninsured: $360 Day surgery: Non-resident: $2770, Uninsured: $1385	
		Diagnostic Imaging	CAT scan: Non-resident: $1570 per test, Uninsured: $785 per test MRI: Non-resident: $1500 per test, Uninsured: 750 per test Ambulance Non-resident: $450, Uninsured: $240 Patients who register and then leave before care is provided will be billed $50	
Cambridge Memorial Hospital		Inpatient	Acute care and rehab: Non-resident: $3150, Resident (Uninsured): $1432 Intensive care unit: Resident: $ 3550, Resident: 1453, Newborn-with mom or special care: Non-resident $1200, Resident: $388 C-section: Non-resident: $720, Resident: $360	Private and semi
		Diagnostic Imaging	Medical imaging Resident: $250, Non-resident: $500 CT Scan Resident: $500, Non-resident: $1500 MRI Resident: $800, Non-resident: $1500	
		Outpatient	ER visit: Resident: $250, Non-resident: $500 Minor outpatient procedures: Resident: $360, Non-resident: $720	

			Fracture clinic Resident: $250, Non-resident: $500 Day surgery: Resident: $1150, Non-resident: $2300	
North Bay Regional Health Centre			Critical care unit: Resident: $3134 Non-resident: $7102	Private and semi
Southlake Regional Health Centre			Uninsured people required to pay a $7000 deposit	

Appendix E: Interview Guide

Questions for people who have experience holding precarious immigration status:

Advocacy work:

1. Can you tell me a little bit about the activist work you are involved in and any organizations/groups that you are affiliated with?

   With activist groups you're part of:

   - How long have you been involved?
   - What are some of the central goals of the activist group that you are a part of?
   - What are some of the strategies and/or tactics that you, or the advocacy group you are a part of, use to achieve these goals? (mobilizing, raising awareness, fighting back, resisting, increasing access, focusing on questions of deservingness, etc.)?
   - How do the group(s) you are a part of discuss or understand differences in access that occur between precarious folks who fall into different immigration categories? (Probe for movement strategies: health for all, status for all)

2. Why and how did you decide to become involved in activist work?
   - Can you elaborate a little bit on the different organizations that you've been a part of or that you have collaborated with throughout the years and how you have connected with them?

Lived Experience:

3. If you feel comfortable, can you tell me a little bit about the different immigration statuses that you've held while living in Canada?
   - Any sort of barriers you've faced in accessing healthcare yourself?
     - Where would you go to seek healthcare (if you did)?
     - Ways that your access to healthcare changed with changes in your status?
     - Experiences facing discrimination based on gender, racism, sexuality, etc. that you have experienced yourself or seen others living with precarious status face while seeking healthcare?
     - How has your access to health care services changed with these changes in status?

4. Where do you/did you go for health problems? (walk-in clinic, hospital, community health centre, doctor's office, etc.? How did you find out about the clinic, CHC?

5. What sort of barriers do you/have you face/d when seeking medical care? (financial, bureaucratic, fear, discrimination)

6. In what ways has your advocacy been informed by your own experience?

7. What are/have been some things that you do that make your access to health care easier?

Reflecting on Advocacy Work:

8. What have been some strategies and practices that you use/have used in the past to facilitate access for yourself or those that you have assisted?

9. Can you share any moments, stories, or memories over the course of your advocacy work that have stuck with you or are particularly memorable for you?

10. What have been the difficult moments in your advocacy work, and what have been moments that you feel positive about?

11. What gains have you seen happen relating to increased health care access for people with precarious immigration status over the course of your advocacy work?

12. In what ways have advocates made a difference for people with precarious immigration status?
    - Do you feel that these are short-term changes or long-term changes? (individual or broader changes in access)

13. I am also interested in how, through your personal experiences and/or advocacy work, you have shared the barriers you've faced to access and the strategies you've taken to address these barriers with others. Can you tell me about a time when you've shared these experiences or ideas with others?

14. How have you changed the strategies or practices that you use in your advocacy work over the years?
    - Can you tell me about what led to these changes?
    - How have your strategies and practices changed with changes to policy, movements (such as IFH), networks or invitations from specific healthcare providers or organizations?

15. Can you tell me about your experience advocating throughout the pandemic if you've been doing activist work during this time?
    - What barriers have you seen come about as a result of COVID?
    - How have you changed your strategies and/or practices as a result of COVID?
    - How has your job changed?
    - What has been made easier with the Directive allowing for everyone to access healthcare?
    - What has still been difficult through the pandemic when you assist people with precarious status?
    - What are your thoughts about keeping healthcare for all Directive?
    - What challenges do you anticipate if/when the Directive is pulled?

Broader/Structural:

16. From your experiences, what would you say are the biggest issues regarding healthcare access for people living with precarious immigration status?

17. What could healthcare workers do to better assist people with precarious immigration status in navigating through the healthcare system?

18. Is there anything that you would like to talk about that we didn't discuss?

Questions for health workers and allied health workers:

Demographic:

1. How long have you been a healthcare worker (or in your current position)?
    - What is your current job title?
    - Why did you decide to become a healthcare worker?
    - Can you provide me with a walk-through of what a "regular" day looks like for you at your job?

Advocacy Work:

2. Can you tell me a little bit about the activist work you are involved in?

3. What organizations/groups are you affiliated with?
    - How long have you been involved in activist work around status/health care for all?
    - Why and how did you decide to become involved in activist work?
    - What are some of the central goals of the activist group(s) that you are a part of?
    - What are some of the strategies and/or tactics that you, or the advocacy group you are a part of, use to achieve these goals? (mobilizing, raising awareness, fighting back, resisting, increasing access, focusing on questions of deservingness, etc.)?
    - How do the group(s) you are a part of discuss or understand differences in access that occur between precarious folks who fall into different immigration categories? (Probe for movement strategies: health for all, status for all)
    - What gains have you seen happen relating to increased healthcare access for people with precarious immigration status over the course of your advocacy work? (Probe for selective/temporary access or widespread/ permanent access)
    - Can you share any moments, stories, or memories over the course of your advocacy work that have stuck with you or are particularly memorable for you?
    - In what ways have advocates made a difference for people with precarious immigration status?

4. Why and how did you decide to become involved in activist work?
    - Can you elaborate a little bit on the different organizations that you've been a part of or that you have collaborated with throughout the years and how have you connected with them?

Reflecting on Advocacy Work:

5. What are some successes that your organization, or others, have achieved?
    - How do you think that these successes can be sustained?

6. How has your activist work been informed and influenced by your experiences as a healthcare worker? How has your health care work been informed or influenced by your activism?

7. If you find that someone presenting at your work has precarious immigration status or is uninsured, what sort of challenges do you face in ensuring they are seen in your practice?
    - What have been some strategies and practices that you use/have used in the past to facilitate access?
    - Are there certain groups/networks/individuals that you reach out to for assistance?
    - What are some of the ways that you are able to tackle discrimination against people with precarious immigration status in institutional settings?

8. How do you make difficult choices about who to serve or not serve - based on the urgency or the patient's need, limitations you face, such as time constraints, or what channels they go through to be seen, i.e., partnership with CHC vs. presenting at the hospital?

9. How have you changed the strategies or practices that you use in your advocacy work since you started?
    - Can you tell me about what led to these changes?
    - How have your strategies and practices changed with changes to policy, movements (such as IFH), networks or invitations from specific healthcare providers or organizations, and contact with specific people/cases?

COVID Related:

10. How has your care/service delivery towards people with precarious immigration status changed with COVID?
    - How did the number or frequency with which people with precarious immigration status presented at your work change with COVID?
    - (For nurses/doctors) With COVID, what changes were made within your (hospital/clinic) regarding how you were asked to work with or treat people with precarious immigration status?

- What reasons did the (hospital/clinic) give for these changes in working with/treating people with precarious immigration status? (public health concern, need, etc)?
- (For administrative staff): After COVID what changes were made to the procedure for charging people with precarious immigration status at your job?
- What barriers have you seen come about as a result of COVID?
- How have you changed your strategies and/or practices as a result of COVID?
- How has your job changed?
- What has been made easier with the Directive allowing everyone to access healthcare?
- What has still been difficult through the pandemic when you assist people with precarious status?
- What are your thoughts about keeping healthcare for all Directive?
- What challenges do you anticipate if/when the Directive is pulled?

Broader/Structural:

11. Can you tell me about a moment in your activist work that you found challenging? When have you felt that your activist work was rewarding?

12. What do you think are the most important issues facing persons with precarious status in accessing health care?

13. What suggestions do you have to improve access to health care services for people with precarious immigration status?

14. Is there anything that you would like to talk about that we didn't discuss?

Questions for community organizers:

Advocacy Work:

1. Can you tell me a little bit about the activist work you are involved in?
    - How long have you been involved in activist work around status/health care for all?

2. Why and how did you decide to become involved in activist work?
    - Can you elaborate a little bit on the different organizations that you've been a part of or that you have collaborated with throughout the years and how have you connected with them?

3. Are there any specific organizations/groups that you are affiliated with?
    - What are some of the central goals of the activist group(s) that you are a part of?

- What are some of the strategies and/or tactics that you, or the advocacy group you are a part of, use to achieve these goals? (mobilizing, raising awareness, fighting back, resisting, increasing access, focusing on questions of deservingness, etc.)?

4. What are some of the successes you or others have achieved?
    - How do you think that these successes can be sustained?

5. What gains have you seen happen relating to increased healthcare access for people with precarious immigration status over the course of your advocacy work?
    - Do you see these as short term/temporary/specific, or wider/long-term/systemic?

6. How have you changed the strategies or practices that you use in your advocacy work since you started?
    - Can you tell me about what led to these changes?
    - How have your strategies and practices changed with changes to policy, movements (such as IFH), networks or invitations from specific healthcare providers or organizations?

COVID related:

7. Can you tell me about your experience advocating throughout the pandemic if you've been doing activist work during this time?
    - What barriers have you seen come about as a result of COVID?
    - How have you changed your strategies and/or practices as a result of COVID?
    - How has your job changed?
    - What has been made easier with the Directive allowing everyone to access healthcare?
    - What has still been difficult through the pandemic when you assist people with precarious status?
    - What are your thoughts about keeping healthcare for all Directive?
    - What challenges do you anticipate if/when the Directive is pulled?

Broader/Structural:

8. Can you share any moments, stories, or memories over the course of your advocacy work that have stuck with you or are particularly memorable for you?

9. Can you tell me about a moment in your activist work that you found challenging? When have you felt that your activist work was rewarding?

10. What do you think are the most important issues facing persons with precarious status in accessing health care?

11. What suggestions do you have to improve access to health care services for people with precarious immigration status?

Appendix F: Glossary of Terms

Affect/emotion: This dissertation discusses Affect and emotion as similar concepts. Affect is understood as part of what emotions do and as a way of examining how individuals move and negotiate relations across various contexts (Schmitz & Ahmed, 2014).

Bordering/Boundaries: the organized structure by which social and political order is controlled through "ideology, cultural mediation, discourses, political institutions, attitudes and everyday forms of transnationalism" (Bendixsen & Näre, 2024; Yuval-Davis, Wemyss, & Cassidy, 2018, p. 229). It is through this everyday bordering that decisions are made about not only "who is and who is not entitled to enter the country, but also whether those who do would be allowed to stay, work, and require civil, political, and social rights" (Bendixsen & Näre, 2024, p. 5).

Coalition-building: The process by which separate activist groups agree to cooperate and work together towards a common goal (Gawerc, 2021) – particularly through the formation of affective connections and emotional bonds.

Compassion: The literature defines compassion in various ways, ranging from feelings of pity to solidarity (Maestri & Monforte, 2020, p. 922; Sirriyeh, 2018; Theodossopoulos, 2016).

De/bordering: The act of activists using strategies individually and collectively (through coalition-building and solidarity) to challenge health inequities for individuals with precarious immigration status in and outside social movement[37] spaces.

Deservingness: Defined in various ways across migration and social theory literature, but often in relation to issues of citizenship, through moral judgment, and access to rights (Carmel and Sojka 2021; Chauvin & Garcés-Mascareñas, 2014; Holmes et al., 2021; Huschke, 2014; Ratzmann & Sahraoui, 2021; Willen & Cook, 2016).

Differential inclusion: the varying degrees of discrimination, racism, and exploitation that shape social inclusion and result in unequal access to rights and resources (Casas-Cortes et al. 2015). Processes of differential inclusion are reinforced and perpetuated by state and institutional bordering practices, where inclusion and exclusion are managed through bureaucratic and administrative policies and discretionary practices shaping social service access, including access to healthcare (Bendixsen & Näre, 2024; Dimitriadi & Sarantaki, 2019).

Humanitarianism: Forms of care and support that are formalized, bureaucratized, and oriented towards alleviating the suffering of those considered vulnerable (Ambrosini, 2022; Cuttitta, 2018; Ticktin, 2014).

Interim Federal Health (IFH) Coverage: Federal healthcare coverage for refugees and refugee claimants while their claim is under consideration. Coverage includes certain healthcare services, including prescription coverage (Government of Canada, 2022). Clinics and pharmacies must register as an IFH provider to process IFH-related healthcare services.

Migrant health activists/Activists: Street-level actors engaged in actions to negotiate to secure healthcare for migrants with precarious immigration status and advocate to better their access to

care. In this research, includes community organizers, front-line workers, and civil society members with personal experiences of precarious immigration status.

Moral/Emotional Distress: Moral distress arises from both institutional constraints and internal moral values (Čartolovni et al., 2021). Moral distress refers to knowing the right moral actions but being unable to act due to institutional or systemic constraints (Weinberg, 2009; Smith et al., 2022).

Physician and Hospital Services for Uninsured Persons (PHSUP) Policy: Introduced in March 2020 by the Ontario Ministry of Health as a temporary measure related to the COVID pandemic. The policy stated that everyone, regardless of immigration status, was entitled to healthcare access free of charge and revoked in March 2023.

Precarious immigration status: Defined as the "absence of permanent residence; lack of work authorization; depending on a third party for residence or employment rights; restricted or no access to public services and protections available to permanent residents (e.g. healthcare, education, workplace rights); and deportability" (Goldring, Berinstein, & Bernhard 2009, pp. 2-3). People with precarious immigration status can move between many different status categories (e.g., student, refugee, temporary worker, asylum seeker, visitor, non-status person).

Re-bordering: The process by which the denial or restriction of access to social services, rights, or entitlements occurs.

Social Movements: Goodwin and Jasper (2009) define social movements as the "conscious, concerted, and sustained efforts by ordinary people to change some aspect of their society by using extra-institutional means" (p. 3)

Solidarity: Often emerges from the building of coalitions. It can be defined as "the ability of actors to recognize others and to be recognized, as belonging to the same social unit" (Melucci, 1996, p. 23) and "involves commitment, and work, as well as the recognition that even if we do not have the same feelings, or the same lives, or the same bodies, we do live on common ground" (Ahmed. 2014, p. 189).

Stories/narratives: Include a plot with a beginning, middle, and end embedded within specific contexts and generally involve a moral element (Polletta, 2006).

Strategies: In reference to activists, practices used to negotiate healthcare access and challenge exclusionary healthcare systems.

Street-level actors: Service providers who use their discretion to provide services to the public. I define these as service providers in paid and unpaid front-line roles, including volunteers, community organizers, and community members.

Temporary Migrant Workers (TMW): Temporary migrant workers in Ontario face challenges accessing healthcare due to systemic exploitation and discrimination linked to their employment and immigration status. This entanglement makes it difficult for them to request health insurance from employers.