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Health of Migrants with Precarious Status: Results of an Exploratory Study in Montreal—Part B

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Increasingly, migrants with precarious status (MPS) are recognized as being particularly vulnerable. This exploratory study assesses whether the health of MPS in Montreal, Canada, is similar to that reported in the international literature (see Health situation of migrants with precarious status: Review of the literature and implications for the Canadian context—Part A, Social Work in Public Health, 27*(4), 330–344). The results of this study show that, as in other parts of the world, MPS in Canada appear to be confronted by multiple obstacles to health, many of which are linked to their precarious migration status and its impact on living conditions and access to health care. To reduce health inequalities, therefore, it is crucial to better understand and address the specific needs of this highly vulnerable population.*

KEYWORDS Migrants, health inequalities, precarious status, living conditions, access to health care

INTRODUCTION

The literature review on the health of migrants with precarious migration status (MPS) in Montreal, Canada, highlighted their vulnerability with regard to health.[1] This heterogeneous population is little studied in Canada, but the consensus from international studies supports the hypothesis that most MPS face deleterious health determinants and do so to a degree that varies with status and context (Crépeau & Nakache, 2006; Gajic-Veljanoski & Stewart, 2007; Médecins du Monde [MdM], 2007; Platform for International Coopera-

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tion on Undocumented Migrants [PICUM], 2007; ter Kuile, Rousseau, Muñoz, Nadeau, & Ouimet, 2007; World Health Organization [WHO], 2005). From the perspective of equity and social justice, it is thus important to better understand this population's needs and to be better equipped to meet them.

By definition, a MPS was born in another country and, for various reasons, does not have legal status, or has a precarious migration status, because it is neither permanent nor guaranteed. The Canadian immigration system allows for various categories of precarious status; MPS comprise a very heterogeneous population. Thus, the literature review and the current context of migration suggest that the MPS experience in Canada resembles that elsewhere, with the associated impacts on their health and that of their host community. This article presents the results of a preliminary study aimed at exploring the similarities between Canada and other countries in the living conditions and health of MPS.

METHOD

Although MPS differ, they do all share a large number of sociodemographic characteristics, living conditions, elements of vulnerability, and the fact that they often shift between one migration status and another. The subpopulations studied here are refugee claimants, temporary foreign workers, live-in caregivers, victims of human trafficking, people who cannot be removed to their country of origin because the Canadian government has placed a moratorium on removals to it (hereinafter called people from moratorium countries), and undocumented migrants.[2] To this list we have added new immigrants, whose migration status is not precarious, but who do encounter particular problems in accessing care.

It is difficult to determine exactly the number of MPS in Canada (Caulford & Vali, 2006; Canadian Council for Refugees [CCR], 2005; Crépeau, Nakache, & Atak, 2006; Gajic-Veljanoski & Stewart, 2007; Simich, Wu, & Nerad, 2007; ter Kuile et al., 2007); this population is less well documented here than in the United States of America and in Europe, notably because of the variety of situations, the clandestine situation of certain MPS, and the lack of access to official statistics. Data recorded in the literature was thus combined with data from interviews to compile the estimates in Table 1.

The method chosen for drawing an exploratory portrait of MPS in Montreal consists of semidirected interviews with those who help these migrants: researchers, members of community organizations, caregivers, interveners, representatives of official organizations, and so on. A set of questions was drafted and, once tested and adjusted, was used in interviews with informants. Interviewees were selected by the so-called snowball method[3] (Van der Leun & Kloosterman, 2006), taking care to include all categories of MPS in the final sample. In total, 24 interviews were carried out so as to reach an

TABLE 1 An Estimate of the Number of Immigrants with Precarious Status in Canada

Categories of precarious immigration status	Hard data and estimates
New immigrants (< 3 months)	219,157[a] Canada, 37,575[a] Quebec (arrived in 2006) (Citizenship and Immigration Canada [CIC], 2007)
Refugee claimants	21,380[a] Canada, 18,700[a] Quebec (newly arrived in 2006) (CIC, 2007) 37,513[a] Canada (undecided claims, December 2007) (IRBC, 2008)
Temporary foreign workers	112,658[a] (annual entries 2006, all categories: foreign workers who are qualified or nonqualified, seasonal workers, and live-in caregivers) (CIC, 2007)
Victims of human trafficking	600 to 800[b], annually, plus 1,500 to 2,200[b] in transit to the United States (Government of Canada & Government of United States, 2006), or up to 16,000[b] in Canada (including arranged marriages, etc.) (estimates by a collective of nongovernmental organizations, cited in Gajic-Veljanoski & Stewart, 2007)
Persons from moratorium countries	4,000 to 5,000[b] (estimates for 2000–2004, cumulative figures during the duration of moratoria) (Canadian Council for Refugees, 2005; French, 2008)
Persons shifting status	??
Undocumented migrants	100,000 to 500,000[b] Canada, 20,000 to 50,000[b] Montreal (multiple written sources, personal communications, and unknown sources)

[a]Hard data.
[b]Estimates.

appropriate degree of information saturation. Several communications with other informants helped complete the collection of data. The informants' answers were then compiled in tables and classed by main fields of interest to allow an overview of the data gathered. These tables were then analyzed so as to identify the consensus and conflicting opinions of informants, and the main, health-related points.

RESULTS

Section A: Portrait of Migrants with Precarious Status

Data on sociodemographic characteristics, and on origins. Despite the heterogeneity of MPS, a consensus about their sociodemographic characteristics emerged from the interviews: they are, mostly, young male and female adults. Several have children in Canada, or in their native country. Because of visa requirements, among other reasons, whether they arrived alone or as a family unit depended, in part, on where and how they entered Canada

because of visa requirements, among others reasons. For example, refugee claimants are more likely to be accompanied by family members, whereas temporary workers have to leave their spouses and children behind, often with the hope of having them come to Canada later.

Similarly, the countries from which MPS came were closely linked to the trajectories they followed in coming to Canada: for example, refugee claimants came from unstable or war-torn countries, seasonal agricultural workers from Mexico or Latin America, and live-in caregivers from the Philippines, mostly. Moreover, those MPS who enter Canada legally originate from a range of countries similar to that from which the general population of Canadian immigrants came. It fluctuates, however, with Canadian immigration policy, and with changes in the economic and political situation in the world.

Causes of precarious migration status. According to those interviewed, few migrants enter Canada clandestinely, mainly because of its geographic situation, though this does happen. In fact, the majority of MPS enter with legal status, the principal categories of which are refugee claim made at the border, or temporary worker, visitor, or student visa. In combination with whatever provoked their departure from the country of origin—economic problems, real or perceived insecurity, willingness to abandon the known to secure a better future for their children or others—four main categories of factors intervene to make life more precarious for these migrants after arrival:

- The precariousness inherent in temporary migrant status, or the loss of this status
- The response of Canadian authorities to a request for regularization, and the procedures themselves
- Nonrespect of the rules governing entry into the country
- Clandestine status of some MPS.

Moreover, the state of precariousness can be of very short duration (e.g., people in an irregular situation for a few months while shifting from one status to another), or chronic (e.g., undocumented migrants who stay in the country for several years). Interviewees stress, however, the recent trend to longer duration of precariousness, as immigration policies grow complex, and the delays in handling files grow longer.

In the domain of immigration policies, the refugee claims procedures are often criticized. According to several informants, these procedures, in which a single person evaluates claims, "create undocumented migrants." In addition, procedures for appealing a refused claim have never been set up, though they are called for in the Immigration and Refugee Protection Act. At least, once all means for regularizing status have been exhausted, rejected claimants are faced with a hard choice: return to their original country, seek refuge in a sanctuary,[4] or go underground.

On the other hand, some informants stress the delicate position of victims of human trafficking and people from moratorium countries.[5] The latter must live for years fearing the moratorium will be lifted and they will be removed to their country of origin. Finally, some informants say, the tightening of the criteria for granting legal immigrant status, and the hardening of immigration policies, encourage the criminalization of migrants. Particularly worrisome are the growing tendencies on the part of authorities to detain immigrants and on the part of citizens to see MPS as criminals rather than as vulnerable persons.

Section B: Living and Health Conditions and Needs

The final report of the Commission on Social Determinants of Health (CSDH; 2008) of the World Health Organization cast fresh light on the many determinants that affect health. The CSDH considers that improving the conditions of daily life is essential for rapid reduction of social inequalities of health and, by the same token, improving the health of populations. Five domains are particularly important: equity during childhood and in education, healthy environments, fair employment and decent work, social protection, and universal health care (CSDH, 2008). When the interviewees' answers to our interview questions are analyzed, it is clear that MPS are penalized in all domains identified as crucial by the CSDH.

Equity during childhood and in education. According to several interviewees, most if not all of the social measures that directly affect the health and development of infants and children are not as accessible to MPS as they are to permanent residents of Canada, or are not accessible at all. In the health field, they particularly mention lack of pre- and postnatal care and childbirth services as examples of lost opportunities for improving the health of children. As well, many of these children do not benefit from other childhood services offered, including daycare, and sometimes encounter barriers to schooling, especially if they do not have legal status. If, in general, ways are found to include them at school, they are not included in official lists, and this means the children do not receive diplomas and the school does not receive financing for them. Access to higher education is limited for many MPS of adult age, as much for administrative as for financial reasons.

Healthy environments. Many interveners stress that the environment in which MPS find themselves on arriving in Canada largely determines their state of physical and mental health. The effect of the environment on MPS varies but is greater for the most vulnerable of them. First, MPS are faced with numerous housing problems. Insalubrious and overcrowded apartments, and frequent moves, are the lot of many of them. Their low income, the fact that they possess only temporary or falsified identity papers or none at all, and the fear of being denounced to the authorities are among the factors contributing to such housing conditions. As well, according to informants,

the lack of hygiene and the promiscuity that this often implies directly affect the health of MPS and of the public.

From the social environment point of view—a crucial perspective, but barely mentioned in the CSDH report—many factors affect the mental health of MPS. A troubled, even traumatic, past can make MPS vulnerable even before they leave their country of origin, as can the very nature of their migration trajectory, and their precarious status on arrival. No matter what their degree of vulnerability, MPS will usually be affected by stress, feelings of powerlessness, loss of motivation associated with waiting to acquire status, and isolation. On the other hand, fear of the authorities, fear of being denounced for lack of papers, and constant anxiety about expulsion will, for some of them, cause interpersonal problems and thus further impair their health.

Moreover, a very large number of informants mentioned that family reunification could have a major impact on the mental health of MPS. For reasons of security, financial means, a hasty departure, or conditions imposed on some categories of migration status, many of them, on arrival, have left a spouse and children behind. Before, during, and after this separation, there are major psychological and social consequences not only for the MPS but also for those who remain in their country of origin. In addition, the separation deprives these migrants of a natural support network just when they are experiencing a particularly difficult phase in their lives. Several informants also noted the extra vulnerability of women sponsored by their spouses, for such women sometimes have to endure unbearable situations, including domestic violence, for fear of being sent back to the country of origin. As well, conjugal violence seems disproportionally to affect women of precarious status, no matter what their migration status.

Finally, the legal environment created by procedures for regularization and Canadian immigration policy could have a major impact on the health of MPS. The complexity and length of procedures, the cost of the steps involved, and the risks of exploitation associated with the vulnerability of these migrants and their ignorance of the system further increase their precariousness—just as the very characteristics of many temporary visas impel them to a still more precarious status.

Fair employment and decent work. The informants mentioned that MPS are particularly vulnerable when it comes to work and working conditions. Most MPS have insecure jobs, and many of them, particularly those without papers, work on the black market. The fear of being denounced and fired forces a number of them to accept low pay and working conditions that are sometimes dangerous, and do not respect work safety standards, thus opening the door to exploitation. Language barriers and the fact that their training is not recognized, pose major obstacles for MPS, as for newly arrived immigrants in general. But not having a social insurance number—or a temporary number, as is the case for temporary workers and people from

moratorium countries—further reduces the chances of finding a good job and increases the precariousness of their situation. As well, the growing number of temporary workers and live-in family caregivers are affected by an extra vulnerability because their temporary visas tie them to their employers, and this encourages all kinds of abuse (not only abuses of working standards, but also verbal, physical, psychological, emotional, and sexual abuse).

Moreover, several key informants stressed access to compensation from the Commission de la santé et de la sécurité du travail (CSST)[6] as a major concern. Many MPS—including the undocumented migrants and live-in caregivers—are not admissible at all for compensation, whereas others find access problematic. Thus the desire to perform well and the fear of possible impacts on migration or job status—or, in the case of temporary foreign workers, the fear of losing their visa—means that many MPS do not declare work-related health problems. Hence, though some MPS are, in theory, covered by the CSST, in reality they seldom take advantage of this protection. Some even have to return to their native countries if injured, which further reduces the chances of receiving compensation.

This lack of job security combined with low wages leads to many economic problems for MPS, but the variability of their situations makes generalization difficult. On the other hand, added to these financial difficulties are the debts contracted in their home countries for migration, the sums that many send back to their families, the sizable costs of communicating overseas, of getting established in Canada, and of taking steps here to regularize their status (fees for hearings, lawyers, renewing temporary work permits, etc.). These expenses add up to a significant economic burden and may directly affect health, notably by forcing MPS to limit or delay making so-called compressible expenditures, which are nevertheless essential for health, such as on healthy food, health care, or medicine.

Social protection. Some MPS may enjoy some social protection as a function of their migration status, but most of them meet difficulties in this domain. If MPS often meet the criteria for admissibility to social protection, such as a preventative withdrawal from work during pregnancy, parental leave, employment insurance, welfare, old age pension, and compensation for work accidents, their legal status and a host of barriers—including administrative, cultural, and legal barriers, and the fear of impeding regularization procedures—either block access or greatly complicate it.

Universal health care. According to our informants, MPS, in degrees that vary with their migration status, face numerous barriers to accessing health care services. These disparities complicate things from the point of view of migrants and from that of health care workers and establishments. Table 2 shows four major categories of barriers that, though they do not necessarily mean the complete lack of services, do have many impacts on health. Health care workers in particular reported their concerns about delays in consulting

TABLE 2 Access to Health Care for Migrants with Precarious Status: Four Main Problems and Their Consequences

Concerned migration status	Definition	Free health care	Consequences or difficulties
1. Three month waiting period			
• Immigrants (all) • Temporary workers (all except seasonal agricultural workers)	No health coverage for 3 months after entering the country	• Perinatal care • Care following familial or sexual violence • Diseases affecting public health	• Even acute/urgent health needs are not covered! • Use of informal networks • Delay in consultation and risks of complications • Reduction in quality of care and follow-up • Confusion among patients and caregivers • Major debts • Pauperization of the poorest
2. Interim Federal Health Program			
• Refugee claimants • People from moratorium countries • Victims of human trafficking	Temporary coverage for essential health care financed by the federal government	• Essential health care • Diseases affecting public health	• Temporary program used in the long term • Problems judging whether care is essential • Some clinics/institutions refuse to treat • Administrative problems
3. Links between employment and health insurance			
• Temporary workers (all)	Loss of health coverage with loss of visa (caused by the end or loss of a job)	• Diseases affecting public health • Commission de la santé et de la sécurité du travail (CSST) coverage?	• Loss of health insurance when vulnerability heightened (pregnancy, disease, injury, loss of work/income) • Delay in consultation and risks of complications • Risk of exploitation/tolerance of an unacceptable situation to keep a job & visa • CSST coverage difficult to obtain for seasonal workers, and not available for live-in caregivers.
4. No health insurance			
• Visitors (including spouses of permanent or temporary residents) • Persons shifting from one status to another • Undocumented migrants	No health coverage	• Diseases affecting public health?	• No health care • Use of informal networks • Fear and avoidance of official structures • Delay in consultation and risks of complications • Reduction in quality of care and follow-up • Confusion among patients and caregivers • Major debts • Troubled interface between the immigration and healthcare systems and even poor treatment

doctors and the aggravation of initial health problems that such delays often lead to. They also reported that they had to provide inferior care because of a reduced range of accessible services, and that they had to contend with the impossibility of following up. Some also noted that they sometimes had to bend the rules of their establishment, to call on colleagues to provide free care and carry out numerous steps to find solutions for the problems of MPS. In other words, given that in practice health care delivery is largely based on the good will of individuals, on chance, and on informal networks, the hardening of internal rules of various organizations makes it increasingly difficult to help MPS.

The key informants particularly stressed the difficulty for MPS of paying for care. All are not penniless, but many are in a precarious economic situation, and a major expense, such as that on health care, can turn them into paupers. Like the delay in seeking care, a major debt often leads to stress and suffering for those not covered by public health insurance.[7] Some MPS repay their medical expenses during a number of years, whereas others, lacking means, will never do so. As well, some of these expenses remain the responsibility of the state, thus wiping out the "savings" realized by the health system by not treating the MPS free of charge. On the other hand, some informants reported witnessing abusive practices by some hospitals in recovering costs. The most common of these practices consists of requiring that pregnant women make a deposit of from $5,000 to $10,000 to cover all the costs of prenatal care and delivery. Another such practice is withholding the child's declaration of birth. Finally, recourse to bailiffs—which can represent a stressful, even traumatic experience for MPS—is quite common.

The fact that treatment of certain diseases (and, in particular, of tuberculosis) is free and accessible to all does not mean that there are no public health issues linked to the lack of health care for MPS. The taboos associated with these diseases, the fear of the diagnosis, and the confusion with other more benign illnesses add to the barriers to health care discussed above. Moreover, once medical treatment begins, the risks of no follow-up are enormous because the members of this population are fearful of officials and have changeable migration status. The possibilities of transmitting disease, in other words, are not negligible. Thus, some of our informants worry about the propagation of sexually transmitted infections, HIV/AIDS, and other infectious or congenital diseases, due to lack of vaccination, screening, and treatment. Therefore, according to several informants, poor access to health care on the part of MPS can have a direct impact on the health of Montrealers.

DISCUSSION

The interviews with various key informants working directly or indirectly with MPS in Montreal point out that these migrants face a multitude of

health inequalities. Moreover, as it is the case for several underprivileged populations, these barriers to health often accumulate and mutually interact (WHO, 2004). On the other hand, the current context of migration suggests that the number of MPS will increase in coming years (Crépeau & Nakache, 2006; IOM, 2007), and some data aready indicate the importance of this population in Canada (CCR, 2005; Citizenship and Immigration Canada, 2007; Oxman-Martinez, Lacroix, & Hanley, 2005; Poulin, 2004). Even if the situation of MPS in Canada is poorly documented, it may be very similar to their situation in other countries. The factors that make MPS more vulnerable can be grouped in five categories: the initial individual or general insecurity in the country of origin (United Nations High Commissioner for Refugees, 2006; WHO, 2005); the migration trajectory adding health risks (Gushulak & MacPherson, 2000; Poulin, 2004); the circumstances of life and work on arrival that are distinctly more deleterious than for most people, and even worse than for migrants in general (Azaroff, Lax, Levenstein, & Wegman, 2004; CCR, 2005; MdM, 2007; Wolff et al., 2005); the numerous limits to access to and use of social and health care services (Berk, Schur, Chavez, & Frankel, 2000; Muñoz & Chirgwin, 2007; PICUM, 2007; Simich et al., 2007); and the insecurity of status and long and complex immigration procedures that make MPS even more vulnerable and harm all health determinants (Caulford & Vali, 2006; CCR, 2005; Crépeau & Nakache, 2006; Macklin, 2003; WHO, 2005).

Thus the key findings of this exploratory study are similarities between the conclusions of the review of the international literature and the statements of the key interviewees, and the estimate that there are very many MPS in Canada. Nonetheless it is important to point out nuances, and to indicate certain limits to this account. First, some subpopulations of MPS—such as persons from moratorium countries—probably exist only in Canada, whereas live-in caregivers or temporary foreign workers are present elsewhere, but under different legal conditions. Moreover, the Canadian legal, political, administrative, and cultural context differs from that of other countries, as does the effect this context can have on the circumstances of life and health of MPS, which introduces supplementary differences. As to limits, the methodology used does not allow precise reporting on the situation of MPS in Montreal, or generalizing from the results. That being said, this study constitutes a first step toward a better understanding of this vulnerable and little-known population. Moreover, the way in which interviewees were selected inevitably introduced bias. However, this methodology did allow a wide variety of problems linked to the health of MPS to be identified, and this will be helpful for future studies. This study shows that there are many areas related to the health of MPS that have been studied little or not at all. Finally, despite the limitations of this study and all that remains to be explored, the observations do show that MPS in Montreal face multiple health-related difficulties.

CONCLUSION

MPS, everywhere in the world, constitute a little known group, and one that is particularly vulnerable because it may face a number of harmful health determinants. This leads to concerns about their health, particularly because of the duration of their precarious status, which is sometimes quite long, and the accumulation of health barriers. Moreover, though being in period of considerable instability due to the regularization process, many MPS and their families are going through critical phases in their lives, such as pregnancy or early childhood, and this adds to the seriousness of the long-term effects of their situation. To deal with this problem, it would be particularly useful to better document the effects of the current situation on the health of MPS, on host communities, and on health care systems.

The Commission on the Social Determinants of Health stressed the importance of reducing social inequalities, particularly by improving daily living conditions. MPS, here and elsewhere, face great inequalities in this domain and in health in particular, as shown in the literature and in the results of this exploratory research. Therefore many ethical and humanitarian obligations, issues related to basic human rights, and concern for social justice and equity make it critical that more attention be paid to this vulnerable population.

NOTES

1. See Brabant, Z., & Raynault, M.-F. (2012). Health of migrants with precarious status: Review of the literature and implications for the Canadian context—Part A. *Social Work in Public Health, 27*(4), 330–344.
2. For a more detailed description of the categories of precarious migration status studied, see Table 1 in Brabant, Z., & Raynault, M.-F. (2012). Health of migrants with precarious status: Review of the literature and implications for the Canadian context—Part A. *Social Work in Public Health, 27*(4), 330–344.
3. A preliminary short list was drawn up of those it was deemed essential to meet, and then every person interviewed was asked to suggest other informants. Thus the sample size gradually grew.
4. Sanctuary: a refuge in a place of worship in order to avoid deportation. Inherent to this strategy is recourse to others to meet one's needs, and a public campaign to regularize one's status.
5. People from moratorium countries: migrants to whom Canada has refused to grant permanent residence status, but whose deportations have been put on hold because of the prevalent dangers in their countries of origin.
6. In Quebec, the CSST is the government agency responsible for workers' health and safety and for compensating those who suffer occupational injury or illness.
7. In Quebec, there are two kinds of public health insurance: the Régie de l'assurance-maladie du Québec (RAMQ) looks after health care for residents and citizens as well as for some categories of migrants, whereas the Interim Federal Health Program (IFHP) provides health insurance for essential care for refugee claimants.

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