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Health Situation of Migrants with Precarious Status: Review of the Literature and Implications for the Canadian Context—Part A

ZOÉ BRABANT and MARIE-FRANCE RAYNAULT
Centre de Recherche Léa-Roback sur les Inégalités Sociales de Santé de Montréal, Université de Montréal, Montréal, Québec, Canada

Migrants with precarious status (MPS) are an understudied population. Yet there are indications that they could be particularly vulnerable and confronted to health inequalities. This review of Canadian and international literature highlights that MPS, like other migrants, are confronted with deleterious living conditions and multiple obstacles to access healthcare. However, their status brings additional challenges and harmful health determinants. The situation of MPS may well be similar in Canada, where they could be numerous. Therefore it is crucial to better document this issue within the Canadian context. Part B of this article, reported elsewhere, further explores this topic.

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

INTRODUCTION

At the dawn of the 3rd millennium, the phenomenon of international migrations has grown to an unprecedented scale (International Organization for Migration [IOM], 2007; United Nations High Commissioner for Refugees [UNHCR], 2007; World Health Organization [WHO], 2005). Inequalities within or between countries, combined with catastrophes and conflicts, have prompted thousands of people to leave their countries of origin to seek better economic possibilities or a safer place to live (Oxman-Martinez & Hanley, 2007; UNHCR, 2006; WHO, 2005; Yang & Wallace, 2007). It is estimated that

Address correspondence to Zoé Brabant, Centre de Recherche Léa-Roback sur les Inégalités Sociales de Santé de Montréal, 1301 rue Sherbrooke Est, Montréal, QC, H2L 1M3 Canada. E-mail: zoe.brabant@umontreal.ca

though irregular and temporary migrations go hand in hand with population movements, an increase in migrants with precarious status is foreseeable in the near future (Siguoin, 2007; Sylvain, 2005). Furthermore, different factors such as national security, now omnipresent in some countries, a hardening of immigration policies that reduce legal options for migration, and globalization of markets tend to transform the context of migrations (Crépeau & Nakache, 2006; Dwyer, 2004; Epstein, Hillman, & Weiss, 1999; IOM, 2007; Scott, 2004; ter Kuile, Rousseau, Muñoz, Nadeau, & Ouimet, 2007; Van der Leun & Kloosterman, 2006; WHO, 2005). Together, they favor the creation of multiple temporary migratory statuses and increase the precariousness of migrants in general.

We define *migrants with precarious status* (hereinafter MPS) as people born in other countries who, for a variety of reasons, have no legal status or precarious immigration status because they are neither permanent nor guaranteed. MPS can be asylum seekers, temporary workers, live-in caregivers, victims of human trafficking, people from moratorium countries,[1] or undocumented migrants (see Table 1).

It is extremely difficult to determine exactly how many MPS there are 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). However, given the data on immigration in general, we assume the number is high; it is even considered that immigration categories which confer "precarious status [. . .] account for 72% of incoming immigrants in Canada" (Oxman-Martinez et al., cited in Simich et al., 2007, p. 369), and the figure is rising (Rousseau et al., 2008). Even so, the MPS population is probably one of the least well known in Canada (Simich et al., 2007; ter Kuile et al., 2007). Yet all indications are that these people are particularly vulnerable due to multiple determinants deleterious to health linked to their immigration status (ter Kuile et al., 2007; Van der Leun & Kloosterman, 2006; Wolff et al., 2005). This literature review is the first phase of an investigation whose results will be presented elsewhere (see Health Situation of Migrants with Precarious Status: Results of an Exploratory Research in Montreal–Part B in Social Work in Public Health *27*(5)).

METHOD

The literature review quickly revealed that very little has been written in Canada about MPS, and even fewer empirical studies on the topic have been conducted in Canada or Québec. Likewise, there are few original studies in the international literature. Other types of literature, including grey literature, make up a large part of the documentation we compiled. Moreover, publications on MPS mostly examine the issue from the perspective of rights; in terms of health, access to care has been studied much more than other

TABLE 1 Glossary of Precarious Migratory Statuses Included in the Literature Review

Live-in caregiver	Person hired by an individual to care for children, elderly or disabled people, and who holds a special 36-month visa (97% given to women in Canada)
Asylum seeker	Applicant for refugee status (as defined by the Geneva Convention or as a person requiring protection), while awaiting a decision on his or her status
Immigrant	Person who immigrates to a country with the intention to settle there. Doctors' attitudes and perceptions regarding their experience with pre-natal follow up of undocumented pregnant women, and its the perceived impact of their undocumented status on women's health
Person from moratorium countries (temporary suspension of removals)	Person to whom Canada has refused to grant permanent residence status, but whose deportations have been put on hold because of the prevalent dangers in his or her countries of origin
Victim of human smuggling	Person transported into another country illegally, as requested, by a trafficker or other person, usually in exchange for financial compensation or other (e.g., work), then left to fend for himself or herself
Victim of human trafficking	Person transported to another country—illegally or not—against his or her will (forced, threatened, abused, or other) and destined for exploitation, mostly in the sex industry but also in other types of "modern-day slavery" (Oxman-Martinez & Hanley, 2007, p. 63)
Undocumented individual	Person who does not have lawful permission to be in a country because he or she entered without authorization or has remained in the country beyond the authorized period
Temporary worker	Person who has a temporary work permit (various types of visas)

Sources. Canadian Council for Refugees (2005), Citizenship and Immigration Canada (2007a, 2007b, 2008a, 2008b), Immigration and Refugee Board of Canada (2006), Oxman-Martinez & Hanley (2007), Poulin (2004), and World Health Organization (2005).

health determinants. Finally, temporary, foreign, or illegal workers, as well as undocumented migrants are more frequently the focus of studies; other MPS subpopulations, especially people from moratorium countries and live-in caregivers, are almost absent from the literature.

The key words used for the literature review are *illegal immigrants, undocumented immigrants, clandestine immigrants, uninsured AND immigrants, immigrant workers, temporary workers, caregivers AND immigrants, domestic workers, human traffic, sexual exploitation, immigrant sex workers* and *asylum seekers*. The sources consulted include the following:

- Databases: Pubmed, CINAHL, JSTOR
- Official sites: Immigration and Refugee Board of Canada (IRBC), Citizenship and Immigration Canada (CIC), and others

- Websites of national and international organizations, including the Canadian Council for Refugees (CCR), United Nations High Commissioner for Refugees (UNHCR), and International Organization for Migration (IOM)
- Web sites of community organizations working with migrants in Montréal;
- Web sites of various research chairs.

LITERATURE REVIEW

Context of Migrations

According to Crépeau and Nakache (2006), the "tightening of migration laws and policies in many of the destination countries (including Canada) has led to a decrease in the legal opportunities for international migration" (p. 4). Indeed, this legislative context limits migrants' choices and increases their precariousness, as many authors have noted (Dwyer, 2004; Kullgren, 2003; Médecins du Monde [MdM], 2007a; Rousseau et al., 2008; Scott, 2004; ter Kuile et al., 2007; Van der Leun & Kloosterman, 2006; WHO, 2005). In parallel, the recent increment in temporary visas, in Canada and elsewhere (Azaroff, Lax, Levenstein, & Wegman, 2004; Langevin & Belleau, 2000; Oxman-Martinez & Hanley, 2007; Scott, 2004; WHO, 2005), also facilitates entry for more precarious migrants because if they "do not wish to return home, there is an almost inevitability to the creation of a population of illegal immigrants" (Epstein et al., 1999, p. 3). In addition, the rights conferred to this population of migrants are limited and determined by restricted visas (Bollini & Siem, 1995; Garant, 2008; Guerin, Vold, & Aavitsland, 2005; Langevin & Belleau, 2000; Oxman-Martinez & Hanley, 2007; ter Kuile et al., 2007).

Characteristics of Migrants with Precarious Status

Although several articles highlight the heterogeneous character of this population (Gushulak & MacPherson, 2000; Van der Leun & Kloosterman, 2006), it is acknowledged that MPS are mostly young and evenly split between the sexes (CIC, 2007c). However, they tend to be increasingly female due to the high demand in sectors identified as "feminine" (especially housework, caregiving, and prostitution). Studies of undocumented individuals have shown that many of them had brought children with them or had left their children behind in their countries of origin (Berk, Schur, Chavez, & Frankel, 2000; Wolff et al., 2005). Their situations vary and depend on world events, geographical proximity, immigration tradition in host countries, number of relatives who immigrated previously, and type of visa or migratory status (de La Blanchardière, Méouchy, Brunel, & Olivier, 2004; DuBard & Massing, 2007; Gajic-Veljanoski & Stewart, 2007; Hanley, 2008; Langevin & Belleau, 2000; Lu, Lin, Prietto, & Garite, 2000; MdM, 2007a; Yang & Wallace, 2007).

The causes of precarious migratory status also vary. Some directly involve MPS: asylum seekers awaiting status or who have been refused, human trafficking, inherent precariousness of some visas, multiple administrative constraints and delays, expired visas, country of origin under a moratorium, illegal entry into the country, gap between two statuses, or any other situations that have resulted in not having papers (CCR, 2005; Epstein et al., 1999; Gajic-Veljanoski & Stewart, 2007; MdM, 2007a; Rousseau, Rufagari, Bagilishya, & Measham, 2004; Scott, 2004; Simich et al., 2007; Van der Leun & Kloosterman, 2006). Others are more macroscopic in nature: hardening of immigration policies, relative closing of borders, creation of temporary and conditional visas, dramatic rise in the international sex industry, fluctuating labor demand, widespread economic and political problems in many countries, national security, or globalization (Crépeau & Nakache, 2006; Crépeau et al., 2006; Epstein et al., 1999; Gajic-Veljanoski & Stewart, 2007; Poulin, 2004; Scott, 2004; Van der Leun & Kloosterman, 2006; Wolff et al., 2005).

Living and Health Conditions

The precarious status of MPS has a major impact on their living and health conditions because "[t]his weak position within the legal system is translated in the crucial spheres of life: housing, health care, education, and of course, in the ways of making a living" (Van der Leun & Kloosterman, 2006, p. 60). Moreover, the fact that these situations persist and affect all aspects of the lives of MPS aggravates the negative health impacts (WHO, 2004).

Housing, income, and employment. Overall, researchers noted that the living conditions of MPS are worse than those of average individuals in host countries (Bollini & Siem, 1995; Kullgren, 2003; Wolff et al., 2005). Difficulties finding housing and substandard, overcrowded, or squatted homes are reported (de La Blanchardière et al., 2004; MdM, 2007a; WHO, 2005; Wolff et al., 2005). Several studies have also noted unacceptable living conditions for seasonal workers, particularly unsanitary living environments (Guerin et al., 2005; Scott, 2004). In regard to the economic situation, Berk et al. (2000) stated that in the United States more than 80% of undocumented families live below the poverty line. Many authors also underline the poverty of MPS (Bollini & Siem, 1995; de La Blanchardière et al., 2004; Gushulak & MacPherson, 2000; MdM, 2007a; Ortega et al., 2007; Siguoin, 2007). Some add that health-related debts impoverish MPS even more, as poverty limits access to care (de La Blanchardière et al., 2004; DuBard & Massing, 2007; MdM, 2007a; Muñoz & Chirgwin, 2007).

In terms of employment, MPS often work in positions shunned by a country's citizens (Azaroff et al., 2004; Brush & Vasupuram, 2006; Macklin, 2003). Many MPS work in the underground economy (MdM, 2007a), where exploitation is common (Brush & Vasupuram, 2006; Mehta, Theodore, Mora, & Wade, 2002; Trottignon, 2007; WHO, 2005; Wolff et al., 2005). Moreover,

MPS are afraid to report the omnipresent abuses and unacceptable working conditions; the jobs available to MPS are described as being in the 3D sector: difficult, dirty, and dangerous (Dwyer, 2004; Macklin, 2003). Stricter immigration policies are partly responsible for these conditions because they force MPS to work on the black market in sectors that are even less controlled (restaurant industry, domestic work, etc.) and that favor exploitation (Brush & Vasupuram, 2006; Platform for International Cooperation on Undocumented Migrants [PICUM], 2007b; Van der Leun & Kloosterman, 2006). Associated with other contextual factors, such as labor market volatility and constraints linked to some migratory statuses, this situation increases the job-related vulnerability of MPS (Azaroff et al., 2004; CCR, 2005; Garant, 2008; Van der Leun & Kloosterman, 2006).

Migratory context also has an impact on access to compensation following a work-related accident. In the United States, though the number of migrant workers injured or killed at work hit a record high, compensation payments declined by 25% in the 1990s (Azaroff et al., 2004; O'Donovan, 2006). Yet some authors reported that the risks of dying at work are 2.5 times greater for Latin American workers born outside the United States than the average for American workers (O'Donovan, 2006). This implies that outside factors, such as fewer employment opportunities or fear of losing one's job or of being deported, cut down on the number of complaints lodged with occupational health organizations (Azaroff et al., 2004; Seixas, Blecker, Camp, & Neitzel, 2008).

Social, cultural, and psychosocial environments and impacts on mental health. The many obstacles and delays related to migration and regularization of status lead to isolation and prolonged separation from family, with attending personal suffering and social consequences that go beyond what we can imagine (Bollini & Siem, 1995; CCR, 2005; Garant, 2008; Gushulak & MacPherson, 2000; Rousseau et al., 2004; Wolff et al., 2005), to say nothing of their major impact on mental health (Vivre Ensemble, 2007; WHO, 2005). Conversely, the existence of psychological problems could reduce the chances of MPS to regularize their status (Trottignon, 2007).

MPS face many obstacles related to language, culture, and racism, and probably much more blatantly than immigrants in general because these three aspects are over and above other elements of vulnerability (Bollini & Siem, 1995; CCR, 2005; MdM, 2007a; Oxman-Martinez & Hanley, 2007; Seixas et al., 2008; Simich et al., 2007; WHO, 2005; Wolff et al., 2005). Moreover, immigration procedures and precarious status can have other consequences on mental health: permanent fear of being denounced and deported, stress and anxiety, isolation, violence, and lack of control are all part and parcel of the everyday lives of many MPS (CCR, 2005; Gushulak & MacPherson, 2000; Macklin, 2003; Muñoz & Chirgwin, 2007; Oxman-Martinez, Lacroix, & Hanley, 2005; Wolff et al., 2005). We also note that post-traumatic disorder, depression, and suicide are very common among

these individuals (Gajic-Veljanoski & Stewart, 2007; Gushulak & MacPherson, 2000; Siguoin, 2007).

Other aspects linked to health. A few other points concerning the health of MPS stand out in the literature. First, migrants generally come from underdeveloped countries, signs of which can be seen in the various health determinants to which they have been exposed since birth (Heuveline, Guillot, & Gwatkin, 2002; United Nations Millennium Project, 2005). Moreover, MPS are more often from poorer sectors of society, which are affected to a greater degree by deleterious conditions, and have less access to legal immigration routes (Gushulak & MacPherson, 2000). Higher prevalence of tuberculosis, sexually transmitted infections (STIs) and HIV among these migrants are some of the possible consequences (Asch, Leake, & Gelberg, 1994; Caulford & Vali, 2006; Gushulak & MacPherson, 2000; Rousseau et al., 2008). We must also mention the dangers of the migration trajectory itself, particularly for victims of trafficking and people who enter the country illegally. Exposure to specific risks through these migration routes has multiple effects on the physical, mental, and sexual health of MPS (Gushulak & MacPherson, 2000; Kullgren, 2003; PICUM, 2007b; Scott, 2004; WHO, 2005). Despite all these hardships, these migrants are often in better health when they arrive than host country residents (Ortega et al., 2007; Siguoin, 2007; Wolff et al., 2005; Yang & Wallace, 2007) due to selection process and strict controls at entry, which contribute to the so-called *healthy migrant effect* (Siguoin, 2007).

Access to Care

Barriers to access to care for individuals. Administrative or legal difficulties that prevent MPS from receiving care—such as the complex nature of the procedures or the need to renew the documents confirming health coverage—seem to be getting worse (Bollini & Siem, 1995; MdM, 2007a; WHO, 2005). In Canada, many problems regarding access to care for MPS have been reported, particularly with respect to waiting periods and the Interim Federal Health Program (Caulford & Vali, 2006; CCR, 2005; Ells, 2006; Gajic-Veljanoski & Stewart, 2007; Muñoz & Chirgwin, 2007; Siguoin, 2007; ter Kuile et al., 2007). The restrictive conditions of numerous visas as well as the lack of medical coverage for some MPS are viewed as major barriers to health (Bollini & Siem, 1995; Muñoz & Chirgwin, 2007; Siguoin, 2007; Sylvain, 2005; Wolff et al., 2005). Being excluded from health care is also associated with a particularly crucial element: fear—of losing one's job and visa, of being denounced or deported, or of hurting attempts to obtain regular status (Asch et al., 1994; Azaroff et al., 2004; Berk et al., 2000; Kullgren, 2003; Simich et al., 2007; ter Kuile et al., 2007). Combined with other factors, such fears incite MPS to avoid official health structures, causing them to turn to informal networks, delay consultation, or leave before the end of treatment, as well as problems with follow-up (Berk & Schur, 2001;

Gushulak & MacPherson, 2000; PICUM, 2007a; Scott, 2004; Siguoin, 2007). The blurred boundaries between health services and immigration control are also of concern because of the effects on access to care and related ethical issues (PICUM, 2007a).

Similarly, in the absence of public or private health insurance, MPS are responsible for payment, and financial problems combine with precarious status to delay seeking care (Gushulak & MacPherson, 2000; Kuiper, Richwald, Rotblatt, & Asch, 1999; Kullgren, 2003; MdM, 2007a; Muñoz & Chirgwin, 2007; PICUM, 2007a; Siguoin, 2007; Simich et al., 2007). Such financial inability to pay also pushes clinicians to offer fewer care options to avoid additional fees (Scott, 2004; Siguoin, 2007; Sylvain, 2005). Health institutions that complain about the financial burden of treating MPS sometimes use a variety of strategies to recover their money: confiscation of important documents until reimbursed, checking the person's status before delivering care, calling upon a bailiff, threatening deportation to the country of origin (PICUM, 2007a; Scott, 2004; Trottignon, 2007). The confusion of caregivers and health institutions regarding the health care rights of MPS also complicates treatment of health problems (Dwyer, 2004; Kullgren, 2003; PICUM, 2007a; Scott, 2004; Siguoin, 2007; Trottignon, 2007).

Underutilization of health services by MPS (Azaroff et al., 2004; Berk et al., 2000; Siguoin, 2007; Wolff et al., 2005; Yang & Wallace, 2007) has an impact on their health, especially for those who are most vulnerable (PICUM, 2007a; Rousseau et al., 2008; Scott, 2004; Wolff et al., 2005). For instance, inadequate prenatal care leads to higher rates of abortion and infant mortality, and to greater morbidity in mothers and infants (Bollini & Siem, 1995; Lu et al., 2000; Wolff et al., 2005). Similarly, poor access to care can result in a 4% to 25% increase in mortality (Hadley, 2003). Denying health care also has long-term effects on the health of MPS and communities as well as on the complexity and cost of care (Berk et al., 2000; Gushulak & MacPherson, 2000; Kuiper et al., 1999; Kullgren, 2003; Rousseau et al., 2008; Scott, 2004; Siguoin, 2007; Simich et al., 2007).

Aspects linked to health care organization and services. For different reasons, many countries give MPS free access to some health services, such as treatment for conditions that could threaten public health (especially tuberculosis, sometimes STI and, more rarely, HIV) (Guerin et al., 2005; Kullgren, 2003; Pollard & Savulescu, 2004; Scott, 2004), services targeting pregnant women and young children (Scott, 2004; Siguoin, 2007), and emergency care (DuBard & Massing, 2007; Ells, 2006; Kullgren, 2003; Pollard & Savulescu, 2004). Although good intentioned, this way of proceeding greatly limits access to preventive care and weakens efforts to prevent the spread of various pathologies (Kullgren, 2003; Siguoin, 2007; ter Kuile et al., 2007; WHO, 2005). There are very few contexts in which MPS receive all the care required in the same way as all residents do. That being said, in many places, services outside the public system—offered by religious, charitable, or nonprofit

organizations—fill the gap (PICUM, 2007a). For instance, free, anonymous clinics have opened up in Germany, France, and other European countries, as well as in the United States and Canada (Caulford & Vali, 2006; MdM, 2007a; PICUM, 2007a; Scott, 2004; Sylvain, 2005; Trossman, 2004). Finally, access to other social programs, modeled on access to care and sometimes more restricted, also varies by province and country (PICUM, 2007a).

Access to care and social services in a wider context. First, public health issues are the subject of some studies, particularly because any measure that limits access to care for MPS could cause an increase in communicable diseases among the general population—tuberculosis or STI, for example—even through treatment is free (Caulford & Vali, 2006; Rousseau et al., 2008; Trossman, 2004). Fear, lack of knowledge of initial symptoms, not knowing that services are publicly funded. and elimination of free prenatal screening are some elements that contribute to delays in seeking care and foster transmission of these diseases (Asch et al., 1994; Dwyer, 2004; Kuiper et al., 1999; Pollard & Savulescu, 2004).

Second, on an ethics and human rights level, it is estimated that the right to health is often adversely affected for noncitizens, despite the fact that it is more a human right than a citizen's right, and notwithstanding the fact that it violates basic human rights as defined under international conventions (PICUM, 2007a; Rousseau et al., 2008; Scott, 2004; Siguoin, 2007; WHO, 2005). Similarly, caregivers are confronted with difficult ethical issues concerning MPS: must they respect their oath and provide the necessary care or follow the law and not treat these people (Siguoin, 2007)?

Third, a number of articles try to debunk myths about the social costs linked to migrants. Yet the economic contribution of MPS—directly through taxes, or indirectly through work, purchases, rents, and other items—is enormous, especially when considering their underutilization of services, including health and social services (Mehta et al., 2002; Trossman, 2004). For example, the economic contribution of undocumented workers is estimated at two billion francs in Switzerland and, in the United States, at more than $5 billion in Chicago alone (Leanza, 2008; Mehta et al., 2002). Still cost is commonly used to argue against access to care for MPS. On the other hand, health institutions are faced with increasingly severe administrative constraints, sometimes even to the point of being at odds with their health-care missions (de La Blanchardière et al., 2004; Ells, 2006; Trottignon, 2007); services provided to MPS also result in significant financial burden to these institutions (Rousseau et al., 2008). Prevention and early management of health problems, as opposed to critical and belated emergency care, would result in savings for health systems (Lu et al., 2000; PICUM, 2007a; Pollard & Savulescu, 2004; Trossman, 2004).

Finally, it is stated in the literature that for migrants, the appeal of access to social services is minor compared with that of finding work or reuniting with loved ones, thus refuting the theory that improving services

for MPS would result in a "migrant magnet" (Berk et al., 2000; Mehta et al., 2002; O'Donovan, 2006; Yang & Wallace, 2007). In addition, the spectre of "medical tourism" feeds debate as soon as the issue of care for MPS is raised. Yet "these people don't leave their country, family, loved ones, or their past just for fun or to get medical care. They are escaping war, oppression and misery" (MdM, 2007b [author translation]).

DISCUSSION

This literature review has limitations, especially in terms of quantity and quality of written material on MPS. Indeed, the little that has been written about this issue leads to other types of literature that is not always as rigorous as research articles. The paucity of writings from Canada adds to our reservations as to what the conclusions of this review of the literature means for Canada.

That being said, the first finding is that MPS are disadvantaged in all areas likely to have a significant impact on their health: housing, employment, income, education, family, social and psychosocial environment, and access to health care and social services. These multiple fragility factors can be grouped into five categories. First, there is the initial lack of security in the country of origin, either individual or generalized (UNHCR, 2006; WHO, 2005). Second, there is the migration trajectory which results in additional health risks (Gushulak & MacPherson, 2000; Poulin, 2004). Then, there are living and working conditions upon arrival, clearly more deleterious than those of most people, and even worse than those of migrants in general (Azaroff et al., 2004; CCR, 2005; MdM, 2007a; Wolff et al., 2005). Next, there are the many limits to access and utilization of health and social services (Berk et al., 2000; Muñoz & Chirgwin, 2007; PICUM, 2007a; Simich et al., 2007). Last, the precarious status combined with long, complex migration processes that have a negative effect on all determinants of health (Caulford & Vali, 2006; CCR, 2005; Crépeau & Nakache, 2006; Macklin, 2003; WHO, 2005).

Also, the current migratory context points to increasing numbers of MPS over the next few years (Crépeau & Nakache, 2006; IOM, 2007), and some data reveal the extent of this population in Canada (CCR, 2005; CIC, 2007b; Oxman-Martinez et al., 2005; Poulin, 2004). Although the situation of MPS in this country is not as well documented, it could be very similar to that of MPS in Europe or the United States.

Finally, the literature review highlights many areas of MPS health that have been studied very little, if at all. In particular, most writings raise this topic from a human rights or public health perspective, for example, and very few studies have examined the consequences of deleterious effects on the health of these migrants. There are also very few studies that have examined

at the specific association of factors to which MPS are exposed and when they are exposed, especially from an access to care perspective.

CONCLUSION

In light of this review, it appears that many determinants have a negative effect on the health of MPS. These individuals are confronted not only with language barriers, discrimination and other barriers to employment, services and healthy living conditions, but they also have to deal with additional vulnerability factors linked to their migratory status. Although the Canadian literature is scant, the conclusions reached are quite similar to those in international literature on MPS, suggesting that the situation is much the same in Canada. It is important, to begin by better documenting the issue of MPS in a specifically Canadian context. Our survey, the results of which are presented elsewhere fall within this perspective.

While social inequalities, the global migration context and globalization are driving more and more people to migrate, even into less favorable circumstances, the issue of MPS is significant and growing. Keeping the status quo regarding the health of this population will have an incidence on the health of migrants, communities, health systems, and society in general. As public health usually shows marked interest in the most disadvantaged individuals, in which category MPS certainly fit, it can no longer ignore these precarious migrants.

NOTE

1. 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.

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