Healthcare for All!

Access to Healthcare for Migrants with Precarious Status in the Parc-Extension Neighbourhood of Montreal, Quebec

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Abstract

Cultural health psychology is a field which investigates health behaviours, and which seeks to link those behaviours to the social context in which they occur; globalisation, on the other hand, is a process which allows cultures to come into increased contact with one another. The process of globalisation has been accelerating at such a rapid pace that many wonder whether it will eventually lead to the eradication and replacement of all local cultures at the expense of a single, global culture. If this so-called cultural homogenisation were ever to occur, it may eliminate the necessity of understanding health from a cultural perspective. The present essay will argue, however, that this cultural homogenisation will never truly come to be, and that rather than eliminating local cultures, the process of globalisation instead encourages them to evolve and transform in unexpected ways. The unique status of suicide in Japan will also be examined to make these arguments even more evident. It will therefore be concluded that an understanding of health is necessarily incomplete if culture is not also taken into consideration.

Immigration rates in Canada are increasing, while Canadian immigration law is becoming more restrictive. Immigrants often arrive through cyclical and forced processes of displacement, and then meet strict immigration regulations at the Canadian border (Walia 2013). The right to health is enshrined as a fundamental human right in the Universal Declaration of Human Rights, but complex Federal and provincial policies govern the eligibility of immigrants for health services and interface with the barriers to integration and accessibility that they commonly encounter (Oxman-Martinez et al. 2005; Sikka, Lippel, and Hanley 2011). A growing and global body of research is documenting the inaccessibility of healthcare for immigrants.

In Canada, the Interim Federal Health Program (IFHP) provides basic healthcare coverage for refugee claimants, victims of human trafficking, and people from moratorium countries. For those denied refugee status, the IFHP covers some health services deemed necessary to treat conditions that pose a threat to public health or safety. In Quebec, the government mandates a three-month wait period upon arrival to the province before immigrants can enroll in health insurance coverage. Once the period has elapsed, new immigrants may be eligible for health insurance through the Régie de l'assurance-maladie du Québec (RAMQ). It is mandatory for residents of Quebec to obtain coverage under this plan if eligible under law. During the waiting period, financial inaccessibility and temporary immigration status prevent many newcomers from seeking insurance from third-party providers. Several immigrant groups are ineligible for Federal health coverage and excluded from care in Quebec, thereby suffering significant health consequences (Ter Kuile et al. 2007; Rousseau et al. 2008; Brabant and Raynault 2012b). That migrants with precarious status experience deleterious health impacts when unable to find safe and affordable care is a recurrent and alarming finding of recent studies, and raises questions about ethics in healthcare practice and provision.

Brabant and Raynault define migrants with precarious status (MPS) as "people born in other countries who, for a variety of reasons, have no legal status [...] because they are neither permanent nor guaranteed" (Brabant and Raynault 2012a:331). Legal dependence on partners or employers, the process and requirements of regularization of status, and the particular circumstances by which immigrants come to Canada also confer precariousness (Ter Kuile et al. 2007; Brabant and Raynault 2012b). Accessibility of healthcare for undocumented and migrants with precarious status varies around the country.

A small group of researchers has investigated the practices of providing care for MPS in Montreal health clinics and healthcare institutions over the last decade. Researchers found that some providers discreetly offer services to MPS, while others turn them away outright (Ter Kuile et al. 2007; Rousseau et al. 2008; Brabant and Raynault 2012a). In several studies, front-line professionals have said that restrictive policies challenge their ability to provide care (Rousseau et al. 2008; Ruiz-Cesares et al. 2013). They note the difficulties of having to work at odds with government policy to meet their ethical obligations as nurses and physicians. Studies have also documented the barriers faced by MPS in accessing healthcare services. Two common themes emerge from the literature. Some barriers relate directly to the lived experience of MPS, including fear of exposure, deportation, or impact on status; physical and geographical accessibility; differing notions of health and wellbeing; and misunderstandings of the system. Other barriers are systemic, and include regulations, administrative complications, and outright racism from care providers (Oxman-Martinez et al. 2005; Ter Kuile et al. 2007; Magalhaes, Carasco, and Gastaldo 2010). Ter Kuile and colleagues note that "problems in accessing care may be largely invisible to those working in the system" because MPS are discouraged from presenting with medical conditions (2007:18).

A key barrier faced by MPS seeking care is disempowerment and misinformation about the healthcare system (Oxman-Martinez et al. 2005, Ter Kuile et al. 2007). Organizations working directly with migrant populations dealing with precarious status, report immediate needs for information regarding available services in order to more effectively carry out their support work (Solidarity Across Borders Montreal 2011). Needed information includes specific services available to various immigrant groups and their costs, availability and qualifications for translation services, referral possibilities, and details of the physical accessibility of a healthcare centre. They also note the importance of having allies in the healthcare system.

This research project aims to explore the accessibility of healthcare in the Parc-Extension neighbourhood of Montreal, Quebec for migrants with precarious status, or MPS, who do not have health insurance coverage. Researchers have conducted extensive legal analysis of how Federal and provincial health and immigration policy intersect with accessibility of care for MPS (Oxman-Martinez et al. 2005; Sikka et al. 2011). This project will focus on how the local application of these policies impacts accessibility of care in Parc-Extension from the perspective of front-line health professionals. Specifically, this study explores two questions:

1. What healthcare services are available to MPS in Parc-Extension? What are the barriers faced by patients in accessing care?

2. What policies and practices govern the accessibility of these services? What are the challenges faced by practitioners in delivering care?

Local Context: Montreal, Quebec

Parc-Extension is a neighbourhood in transformation. Part of the Villeray–Saint-Michel–Parc-Extension borough, it is home for approximately 31,000 residents (CDEC 2004). 62 per cent of these residents are born outside of Canada, which is more than twice the average for the city of Montreal (CDEC 2004). Little data exists about the situation of MPS in Parc-Extension specifically; however, about 20,000 to 50,000 undocumented migrants are estimated to be living in Montreal, excluding other categories of legal but nevertheless precarious immigration status (Brabant and Raynault 2012b; Magalhaes et al. 2010).

The local health authority, the Health and Social Services Centre (CSSS) de la Montagne (one of 12 across the city) directs institutional health services in Parc-Extension. The neighbourhood is served by the Local Community Service Centre (CLSC) Parc-Extension, three private clinics, and La Maison Bleue, a family medicine group and non-profit organization affiliated with CLSC Parc-Extension that offers perinatal services. Immigrants in Parc-Extension are also supported by a number of community organizations, which range from youth and neighbourhood associations to migrant support groups. Of note, Solidarity Across Borders is a migrant justice network that supports migrants and their families around Montreal. Médecins du Monde, an international humanitarian organization, also operates Projet Montréal, a mobile clinic staffed by health professionals that provides services including referrals and mental healthcare to immigrants without health coverage in the city.

Studies in Montreal have explored accessibility of care for migrants, but to date no collaborative research assessing the availability and accessibility of formal healthcare services for MPS has specifically focused on the neighbourhood of Parc-Extension. Cuts to Federal-level coverage in 2012 and a recent temporary expansion of the Interim Federal Health Program underscore the need for more current assessments of accessibility of care for MPS groups in the city.

Methodology

Two important concepts guided this research. First, this project seeks to use a community-based and participatory approach. The research questions were developed in collaboration with local community organizations and informed by local needs. The study was focused on a single neighbourhood in hopes of identifying locally applicable policy recommendations. Second, I acknowledge that there exist underlying systemic causes of inequitable access to healthcare including unequal power distribution, racism, and classism; and that people experience intersecting forms of oppression (Walia 2013; Minkler and Wallerstein 2008; Willen, Mulligan, and Castaneda 2011). These cannot be addressed in this methodology.

This project was conceived based on a briefing from Solidarity Across Borders obtained through the Community-University Research Exchange, which identified information about health services needed in order to better support migrants in the city. Following a literature review, research questions were identified in collaboration with members of Solidarity Across Borders and Médecins du Monde. Approval of the ethical acceptability of the research was received from McGill University (McGill REB File #156-1014) and SHERPA, the research centre of the CSSS de la Montagne.

Most participants were identified using the snowball sampling method. A list of clinics existing in Parc-Extension was also obtained from the CSSS, and where individual front-line health professionals had not already been identified through snowball sampling, clinics were telephoned. Of the five clinics operating in Parc-Extension, the three private clinics declined to participate. Three interviews were conducted with front-line healthcare professionals at the two remaining clinics. The participants included a family doctor at the CLSC and two social workers at La Maison Bleue. Prior to each interview, informed consent was obtained, as well as consent to record the audio of the interviews. Responses were analyzed, common themes were identified, and critical discourse analysis was then applied. Finally, local solutions and opportunities for further research were identified.

Results: the state of access to care for MPS in Parc-Extension

This study sought to analyze the status of access to healthcare in Parc-Extension for uninsured MPS by interviewing front-line care providers in clinics in the neighbourhood. Two clinics participated in the study. CLSC Parc-Extension, the local network clinic, houses a number of services including: an appointment-based ambulatory clinic, a walk-in clinic, vaccination services for children, and a chronic illness clinic for patients with conditions including diabetes and hypertension. La Maison Bleue (LMB) is a family medicine group of the CSSS de la Montagne as well as a non-profit organization, which offers perinatal services for women who meet certain vulnerability criteria and medical and social services to their families. Findings from interviews with participants at these clinics are presented and discussed below.

Availability and accessibility of services

A primary objective of this work was to meet local needs by cataloguing the health services available to MPS without coverage in Parc-Extension. At both clinics where front-line healthcare professionals were interviewed, MPS without a RAMQ card and documents proving IFHP eligibility and coverage were accepted for care based on varying criteria. In Table 1, the responses of participants regarding eligibility of uninsured MPS are presented alongside conditions and accessibility details.

Table 1: *Services available for MPS in Parc-Extension*

Clinic	Eligibility of MPS without coverage for services	Accessibility details
CLSC Parc-Extension	Patients without documents accepted during walk-in clinic only	• Walk-in clinic hours: 9 a.m. – 12 p.m. Tuesday & Friday, 9 a.m. – 3 p.m. Wednesday (as of February 2015) • $100 cost per consultation • Translator not available for walk-in consultations
La Maison Bleue Parc-Extension, family medicine group	Patients without documents not accepted, except in limited situations	• Patient must meet vulnerability criteria • If criteria met, MPS without coverage generally only accepted when unable return to country of origin • $160 cost for blood test; additional costs for tests such as ultrasounds • Cost for hospital delivery via payment plans • Translation services available

At the CLSC, uninsured patients are accepted and directed to present during walk-in hours. MPS can then consult with a health professional (a physician, nurse, social worker, nutritionist, et cetera) at a cost of $100 per visit. Uninsured MPS cannot book appointments. One doctor noted that because patients without coverage are only eligible to be seen during walk-in clinic, the availability of a doctor depends significantly on physicians' own decisions to dedicate hours to accepting walk-in patients. As well, because they are only available when booked in advance, uninsured MPS facing language barriers cannot readily access translation services at the healthcare institutions.

At LMB, where services are free to patients through its association with the CLSC as a family medicine group, undocumented patients with precarious status are generally not eligible for the services offered except in specific cases. In Quebec, RAMQ may cover healthcare services related to pregnancy only for pregnant women eligible for RAMQ and waiting for coverage to take effect following the three-month waiting period. In this case, LMB will assist the patient in preparing the appropriate documents explaining their situation should care be required elsewhere (delivery at a hospital, for example). For MPS who fall between the cracks of provincial and Federal coverage, should they meet the SIPPE vulnerability criteria, LMB may accept to see them free of charge, save for costs for blood tests and ultrasounds. Participants interviewed at LMB also noted that for pregnant MPS without residency or insurance papers, they would work to make appropriate referrals for care options, to Médecins du Monde, for example. Hospital fees, however, are separate from the services offered by LMB; for MPS, LMB does not cover costs of delivery and would assist pregnant women in making payment arrangements with a local hospital. One participant noted that monthly payment plans are often arranged, because if payment plans were not established prior to entering into a doctor's or midwife's care at LMB, the costs for delivery would be billed to the clinic, which they are unable to bear.

Barriers faced by migrants with precarious status

Participants from both clinics identified certain accessibility barriers for MPS. A common barrier was financial costs to patients; the doctor interviewed at the CLSC explained that the $100 cost to see a medical professional is charged on every visit, and any prescription medications, referrals, or hospital visits could have further costs. This doctor noted that costs to both patients and the care providers impact the level of care: depending on the clinic's relationship with the pharmaceutical provider, they may need to rely on sample medications and can therefore only prescribe reduced drug regimens. At LMB, cost was a less salient limiting factor; the on-location services were provided mostly free of charge through CLSC funding.

When probed about a representative story of the barriers faced by MPS in Parc-Extension, one participant described a woman who came to Canada from a Caribbean country, gave birth here, and has been living in Canada for more than twenty years. Though her son was able to gain regularized status, she has never submitted an immigration application, and as a result has been unable to properly obtain medication regimens and on a broader level, improve her employment situation or access child support systems. The participant explained that she is worried about penalization or deportation by immigration authorities should she begin the process of attaining Canadian residence status. Commenting more broadly on detention and deportation of undocumented migrants in Montreal, the participant noted the links to deeper issues of systemic racism in Canadian society. Criticizing the use of terms like "illegal immigrant" by government officials and in immigration policy documents, they asserted, "It feeds racism and bigotry, and it doesn't make our work any easier."

A final barrier that participants identified as impacting MPS' access to healthcare services in Parc-Extension was patients' misunderstandings about the healthcare system. Many MPS are unaware of the care to which they are entitled. This issue is especially prevalent following changes to coverage eligibility (e.g. the 2012 cuts to IFHP coverage) when the usefulness of formal communications by mail is contingent on whether the recipient speaks French or English or whether they can find a member of their community who could translate. Participants also raised the issue that MPS, particularly undocumented immigrants, fear disclosure of their status to immigration authorities should they access care. All participants were adamant that confidentiality was of the utmost importance in their practice and that accessing care would have no impact on the status of the immigration application for a patient seeking regularized status. One participant mentioned that administrators were often willing to "look the other way" when physicians provided care for undocumented migrants.

Experiences of front-line health professionals

The healthcare professionals interviewed in this study were asked to speak about their experiences caring for MPS. Participants' professional backgrounds varied: one participant had worked at their clinic for over a decade, a second had been practicing as a social worker in Montreal for twenty years, while the third participant was completing her training at the time of the interview. Participants all believed that migrants with precarious status do deserve equal and equitable access to healthcare services. They discussed challenges they encountered in their practice and how these impacted what services they could actually offer.

A major barrier specific to the CLSC was that physicians could not access funding for the care of uninsured MPS. This forces providers to narrow services for the essential and affordable, and impedes their ability to provide consistent follow-up to patients, meaning they are unable to carry out what they feel is their professional responsibility. As a consequence of these limitations, one doctor explained that physicians must carefully evaluate whether the seriousness of a condition that a given precarious-status patient is suffering outweighs the potential costs to the patient for the procedure, test, or treatment needed. This issue has worsened with increasingly limited financial resources. Participants also described how available clinic resources impacted their ability to personally negotiate on behalf of a MPS for direly-needed procedures or services. They commented on both the difficulty of finding allies in the healthcare system and their inability to advocate for every patient to a level that would guarantee them the care that they need. All participants and informants agreed their work was made more challenging by cuts to funding for health services by the provincial and Federal governments.

According to those interviewed, where participants worked had an impact on health professionals' experiences of caring for MPS. When asked about professional resources specifically available to overcome cultural barriers between patients and care providers, one participant noted that some workshops on cultural awareness were provided by SHERPA, the research branch of the CSSS de la Montagne, which has a research axis dedicated to studying experiences of immigrants accessing care in the region serviced by the CSSS. One participant believed that they learned from the experience of working with patients of various cultures because they encountered MPS so often, and another participant felt that in her place of work, administrators tried to deliberately foster an open-minded attitude toward immigrants. Participants agreed that issues of cultural sensitivity, while present, were much less prevalent than they have been previously, attributing this improvement in part to such resources and efforts.

Solutions and opportunities

All participants were asked about their perspectives on possible solutions to the issue of access to healthcare for MPS. Responses varied from community-level leverage points to changes in provincial and Federal health policy to societal change. At the local level, it was suggested that having dedicated translators at clinics could tackle language barriers when translators from the BII couldn't be arranged for walk-in patients. Participants also noted the value of resources such as trainings on cultural awareness. One participant suggested that these be made mandatory for new physicians, particularly in regions such as Parc-Extension that is home to large immigrant communities. It was also suggested that professional organizations such as the Fédération des médecins omnipracticiens du Québec (FMOQ, the Quebec Federation of General Practitioners) could play a role in disseminating best practices of care for MPS to their members. Finally, participants were in consensus that changes in immigration policy to extend coverage to excluded groups and to facilitate the process of regularization of status continue to be important goals for advocates.

Discussion

Various researchers have worked to catalogue the availability of healthcare services for migrants without status, examine attitudes among healthcare professionals toward providing care for MPS, and understand barriers faced by these populations in accessing care. In this study, I aimed to conduct a comprehensive exploration of accessibility of care within one Montreal community, examining (1) the available services, and (2) the context of policy, practice, and professional attitudes within which these services are offered. Throughout the study, emphasis was placed on community participation through collaboration with Solidarity Across Borders, a migrant justice network in Montreal. In this section, the data is discussed and situated in the context of the Parc-Extension neighbourhood as well as broader Canadian society.

The first goal of this study was to catalogue public health services in Parc-Extension. It was found that care free-of-charge is generally not available to MPS. At the CLSC, migrants without any health insurance or coverage are charged for every visit, while at LMB, MPS must meet certain vulnerability criteria to receive free services, which are focused on perinatal care. These results and responses of participants support findings of numerous studies that a financial burden exists and discourages MPS from seeking care (Ter Kuile et al. 2007; Brabant and Raynault 2012b; Brabant and Raynault 2012a; Magalhaes et al. 2010). Where services are offered to MPS, they are often provided discreetly or as a result of personal negotiation by healthcare professionals on behalf of patients – a situation that has also been demonstrated in other studies (Rousseau et al. 2008; Ruiz-Cesares et al. 2013). Aside from cost, the other barriers to care that participants felt MPS experience include: discrimination by health practitioners, lack of knowledge about coverage of healthcare, and fears of disclosure of their information to immigration authorities, especially where there exists a possibility of detention and deportation. These data reaffirm many previously identified barriers including delayed and denied care (Magalhaes et al. 2010) and obstacles arising from restrictive regulations and burdensome administrative requirements (Ter Kuile et al. 2007).

The second objective of this study was to explore the local policies and practices that govern the accessibility of health services for MPS. In most clinics, little written policy exists on care provision for undocumented and uninsured immigrants. At the provincial and Federal levels, however, the literature has suggested that policy and regulations restrict care provision (Oxman-Martinez et al. 2005; Sikka et al. 2011). I identify several factors that influence the care that front-line workers provide to MPS: healthcare providers' personal experiences, access to professional resources, and their ability to negotiate on behalf of a patient when services at other institutions (e.g. hospitals) are required. In some cases, participants felt forced to provide substandard care due to these difficulties, and noted negative health consequences for patients. Overall, these findings corroborate other studies documenting challenges and attitudes of health professionals (Ter Kuile et al. 2007; Rousseau et al. 2008; Ruiz-Cesares et al. 2013; Magalhaes et al. 2010; Vanthuyne et al. 2013).

Discursive analysis of participants' comments yields a number of observations. Comparing responses from the participant from the CLSC with responses from caregivers at LMB, the former was more likely to identify and describe challenges to the practice and to speak against the broader societal and policy-related issues that impact immigrants' lives. In contrast, LMB workers placed a greater emphasis on maintaining stakeholder and institutional relationships with the CLSC and hospitals in particular. This could be attributed to the fact that LMB also operates as a non-profit organization. Comparatively, because LMB is dedicated to providing perinatal care for vulnerable women, some of the challenges faced by physicians at the CLSC (e.g. cultural barriers) may have been already addressed through practices in place at LMB to meet needs that arise from working with vulnerable populations on a daily basis.

Some inferences can be made about the value systems of the participants. Participants were all generally in favour of more equitable access to care for MPS. Whether or not they were regularly able to provide care for MPS, they all agreed that expansions to provincial and Federal coverage are needed. While participants from LMB placed a particular emphasis on empowerment of patients, nearly all stories and examples that participants recalled "morally orientated" the listener toward empathy with the immigrants who were the subjects of their stories and recognition of injustices within the healthcare system (Hastings 1998:198). Notably, this is not entirely consistent with more expansive studies of healthcare workers where beliefs have been expressed that health is a privilege of citizenship as opposed to a human right (Ruiz-Cesares et al. 2013; Vanthuyne et al. 2013). This is potentially attributable to a bias that exists among the participants due to use of the snowball sampling method. Participants were recruited from informants knowledgeable about the subject of access to care for MPS and it is likely that the participants contacted had a similar knowledge base. It is also worth noting that all participants were employees of public health clinics, since the three private clinics contacted during participant recruitment declined to participate. Furthermore, healthcare providers at volunteer-run clinics such as Médecins du Monde, and other community and alternative health services, were not included in this study.

Methodology: reflections and limitations

Throughout this work, I emphasized a collaborative research process in the hopes of creating useful and applicable knowledge that could improve the accessibility of care for MPS in Montreal and tackle the disempowerment often identified as a barrier. This study sought to provide information regarding the accessibility of healthcare services in Parc-Extension to those that support MPS, including migrant justice groups and volunteer clinics. For two clinics in the neighbourhood, this was achieved to some degree. Responses from participants, however, indicate that different services may be subject to different costs, and that some groups of MPS may be accepted for care while others may not. Furthermore, the practices and policies in private clinics in the neighbourhood are unclear. This yields an incomplete picture of what services are available, and highlights the need to document who can access healthcare in Parc-Extension, the cost of individual services, and accessibility information such as translation services, physical accessibility of buildings, methods of payment, hours of operation where they differ from regular clinic hours, and geographic location. A detailed catalogue of services could be developed through a more structured interview or survey format. Such a research objective must also contend with how to accessibly present findings so that they may be useful to immigrant communities.

An inherent limitation also exists because of who was consulted in developing this profile of available care for MPS in Parc-Extension. Although this work is grounded in an attempt to speak with and not for MPS, certain voices were not directly included here: namely, migrants confronting precarious status. Cognizant of a history of exploitative research of vulnerable populations (Minkler and Wallerstein 2008), along with my inability to provide compensation to MPS and address any psychosocial concerns that could arise in speaking to them about issues of health and accessibility, in this preliminary study, I sought to avoid token inclusion of immigrants in the participant base. Instead, this project works toward meeting the urgent needs identified by research partners who do work directly with MPS. A consequence of this may be a narrow portrayal of immigrants' lived experiences that does not explore immigrants' agency, self-determination, resilience, and successes in overcoming the barriers identified here.

Finally, it should be noted that while a consensus was observed among participants that racism and discrimination make care difficult to access for immigrants, this methodology did not achieve more than a cursory exploration of how issues of systemic oppression impact immigrants' experiences. Many researchers have described how notions of citizenship, construction of some groups of migrants as "illegal," restrictions to regularization of status, and criminalization of these populations result in the hierarchization of identities in Canada, and impact the lives of newcomers (Walia 2013; Ter Kuile et al. 2007; Magalhaes et al. 2010; Brabant and Raynault 2012b). By extension of this framework, critical discourse analysis could be directly applied not just to participants' responses, but more broadly, beginning with perceptions of a 'universal' Canadian healthcare system, and then analyzing societal narratives and public discourse about immigration, vocabulary in research exploring immigration, and language use in government immigration policy documents (Ruiz-Cesares et al. 2013; Willen, Mulligan, and Castaneda 2011).

Future directions: toward more accessible care

This study employed a participatory, community-based research methodology to lay the foundations for a catalogue of health services available to migrants with precarious status in Parc-Extension, identified barriers faced by immigrants in the neighbourhood in accessing care,and explored related challenges that professionals face in two Parc-Extension clinics.

From the results of this study, three actionable research directions have been identified as important for extending this analysis and improving the accessibility of services in Parc-Extension. First, available services and their accessibility information should be more fully catalogued in the neighbourhood, and allies should be identified in the healthcare system: health professionals who could assist workers at community organizations in supporting the migrants with whom they work and organize. Second, professional resources should be designed to support physicians and front-line care providers in working with migrants with precarious status, and training around migrant care issues should be implemented. Third, epidemiological research to better understand the health impacts of inaccessible care should be undertaken.

Precedents such as the "Access Without Fear" policy in Toronto, underscores the possibility of transitioning to equitable and enabling healthcare systems in Canada. Taken together, the findings of this study highlight the need for further local research to better understand the situation of precarious-status immigrants in Montreal, and to strengthen the case for changes to provincial and Federal health as well as immigration policy.

References

Arya, N., McMurray, J., and M. Rashid. 2012. "Enter at your own risk: government changes to comprehensive care for newly arrived Canadian refugees." Canadian Medical Association Journal 184(17):1875-1876.

Brabant, Z., and M. Raynault. 2012a. "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.

Brabant, Z., and M. Raynault. 2012b. "Health of Migrants with Precarious Status: Results of an Exploratory Study in Montreal Part B." Social Work in Public Health 27(5):469-481.

Canadian Doctors for Refugee Care v Attorney General of Canada, FC 651 (2014).

CDEC and l'Arondissement Villeray-Saint-Michel-Parc-Extension, 2004. Portrait de l'arondissement: faits saillants. <https://www.cdec-centrenord.org/filesNVIAdmin/File/portrait_arrondissement2004.pdf> Accessed December 5, 2014.

Centraide of Greater Montreal, 2012. Territorial Analysis 2012: Villeray, Saint-Michel, and Parc-Extension. <http://www.centraide-mtl.org/en/documents/4506/upload/documents/CEN_12_Portrait_de_territoire_Villeray_Saint_Mich_Parc_Ex_E_02_FINAL.pdf/> Accessed November 23, 2014.

Hastings, A. 1998. "Connecting Linguistic Structures and Social Practices: a Discursive Approach to Social Policy Analysis." Journal of Social Policy 27(2):191-211

Magalhaes, L., Carasco, C., and D. Gastaldo. 2010. "Undocumented Migrants in Canada: A scope literature review on health, access to services, and working conditions." Journal of Immigrant and Minority Health 12(1):132-151.

Minkler, M., and N. Wallerstein, eds. 2008. Community-Based Participatory Research for Health: From Processes to Outcomes. San Francisco: Jossey-Bass.

Oxman-Martinez, J., Hanley, J., Lach, L., Khanlou, N., Weerasinghe, S., and V. Agnew. 2005. "Intersection of Canadian Policy Parameters Affecting Women with Precarious Immigration Status: A Baseline for Understanding Barriers to Health." Journal of Immigrant Health 7(4):247-258.

Rousseau, C., ter Kuile, S., Munoz, M., Nadeau, L., Ouimet, M., Kirmayer, L., and F. Crepeau. 2008. "Healthcare Access for Refugees and Immigrants with Precarious Status." Revue Canadienne de santé publique 99(4):290-292

Ruiz-Cesares, M., Rousseau, C., Laurin-Lamothe, A., Rummens, J., Zelkowitz, P., Crepeau, F., and N. Steinmetz. 2013. "Access to Healthcare for Undocumented Migrant Children and Pregnant Women: The Paradox Between Values and Attitudes of Healthcare Professionals." Journal of Maternal and Health 17:292-298.

Sikka, A., Lippel, K., and J. Hanley. 2011. "Access to Healthcare and Workers' Compensation for Precarious Migrants in Quebec, Ontario and New Brunswick." McGill Journal of Law and Health 5(2):203-269.

Solidarity Across Borders Montreal. 2011. "Briefing: health care for All! Access without fear for non-status migrants." Community-University Research Exchange, <http://curemontreal.org/healthcare-for-all-access-without-fear-for-non-status-migrants-solidarity-across-borders-montreal> Accessed December 12, 2014.

Ter Kuile, S., Rousseau, C., Munoz, M., Nadeau, L., and M. Ouimet. 2007. "The Universality of the Canadian Healthcare System in Question: Barriers to Services for Immigrants and Refugees, International Journal of Migration." Health and Social Care 3(1):15-26.

Vanthuyne, K., Meloni, F., Ruiz-Cesares, M., Rousseau, C., and A. Ricard-Guay. 2013. "Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or privilege?" Social Science & Medicine 93:78-95.

Walia, H. 2013. Undoing Border Imperialism. Edinburgh: AK Press UK.

Ward, K. 2013. Researching the City: A Guide for Students. London: SAGE Publications Ltd.

Willen, S., Mulligan, J., and H. Castaneda. 2011. “Take a Stand Commentary: How Can Medical Anthropologists Contribute to Contemporary Conversations on “Illegal” Immigration and health?” Medical Anthropology Quarterly 25(3):331-356.