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Migrant Women's Health & Housing Insecurity: An intersectional analysis

Intersections of women experiencing migration and housing insecurity in Canadian contexts have rarely been examined. In this article, we present an analysis of how health intersects with the experience of housing insecurity and homelessness, specifically for migrant[1] women. We argue that it is important to understand the specificities of the interplay of these different factors to continue the advancement of our understanding and practice as advocates for health and housing security.

We begin with an overview of the literature to present different bodies of work that contribute to our understanding of the topic. We then describe the methods used in the qualitative, Montreal-based research project from which data for this article are drawn. Our findings are presented around three themes: how health problems instigate and maintain migrant women's housing insecurity and homelessness; ways in which women's immigration trajectories and legal status may influence their health experiences; and particular coping strategies that migrant women employ in efforts to maintain or manage their health. We conclude with implications of these findings for both policy and practice in relation to migrant women who experience or are at risk of housing insecurity and homelessness.

[1] One of the objectives of this project was to explore housing insecurity across the range of women's migration experiences, from the most precarious undocumented women, through refugee claimants, international students, temporary foreign workers and permanent residents. As well, most of our participants have passed through multiple immigration statuses during their time in Canada, so it was sometimes difficult to specify their status at the moment they were referring to in their comments. We analyze the role of immigration status more indepth elsewhere (Blinded) but here we use the generic term of "migrant" to reflect the range of immigration statuses included in our study and to avoid unnecessarily putting women's experiences into bureaucratic boxes.

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A REVIEW OF THE LITERATURE: INTERSECTIONS OF HEALTH AND HOMELESSNESS AMONG MIGRANTS

Literature related to health and homelessness among migrant women in Canada can be divided among three distinct categories: (a) housing and homelessness among migrants to Canada (e.g., Guirguis-Younger et al., 2014); (b) health of migrants in Canada (e.g., Chen et al., 1996; Vang et al., 2017); or (c) health of women living in situations of homelessness (e.g., Cheung and Hwang, 2004; Flentje et al., 2017). With few exceptions (see for example, Newbold, 2010 and Chiu et al., 2009), analyses have rarely considered the interactions of housing and health among migrant women in Canada, although international studies are emerging (Calvo et al., 2017; Moya et al., 2017). Although a social determinants of health framework implies the desirability of examining these relationships, previous endeavors have offered only limited insight into the health-related causes and consequences of homelessness among migrant women. Social determinants of health are described by Raphael (2009), as "the economic and social conditions that shape the health of individuals, communities, and jurisdictions…" (p. 2). They imply that efforts to investigate the connections between social factors (such as gender, racialized identity, housing, and migration status) and health are warranted.

Housing and homelessness among migrants to Canada

Homelessness scholars distinguish between absolute and relative forms of homelessness. While the former represents more visible forms, including sleeping rough and accessing shelters, the latter represents far fewer tangible manifestations characterized by a lack of stable, sustainable or safe housing conditions (Echenberg and Jensen, 2008). This distinction is particularly significant for understanding the housing situation of immigrants and refugees in

Canada, as there is a general consensus that migrants are under-represented among those living in absolute homelessness (Fiedler et al., 2006; Hiebert et al., 2005), but over-represented among those in relative homelessness (Fiedler et al., 2006; Haan, 2010; Preston et al., 2009; Rose et al., 2012). This over-representation of migrants in precarious housing situations means that they are more likely to be found "doubling up", "couch surfing", paying unsustainable proportions of their income toward housing costs, and/or living in unsafe/unsuitable housing conditions. Using 2006 census data, Haan (2010) found that the odds of immigrants living in overcrowded housing were 1 in 14 compared to the non-immigrant population, whose odds were 1 in 60. Also 36% of migrant households lived in "unacceptable housing conditions" compared to 13% of non-immigrant households (Wayland, 2010, p. 22) Further, the majority of refugees in Montreal were spending more than half of their incomes on housing, compared to the non-immigrant population, most of whom spent less than one third (Rose, 2001). Thus, while migrants may be less likely to find themselves in a homeless shelter, they are more likely to suffer from the consequences of invisible forms of homelessness that are inherently more difficult to measure, let alone to address.

Numerous studies have compared the housing status of migrant and non-migrant populations; other studies have attempted to go deeper, by comparing the housing status and trajectory of different categories of migrants. This research has shown that there is greater vulnerability to homelessness and housing instability among those who are newer to Canada (Canada Mortgage & Housing Corporation, 2007; Rose et al., 2012; Williams, 2003), those who are refugee claimants (Murdie, 2008; Rose and Charette, 2011), those without status (Paradis et al., 2009), and those of non-European descent (Williams, 2003). Furthermore, very little work has been done to differentiate the housing status of migrants according to gender (Klodawsky,

2006; Novac et al., 1996). In the general population, women have been found to experience homelessness differently from men (Brown and Bourbonnais, 1996; Conseil des Montréalaises, 2006; Klodawsky, 2006) while both women's homelessness and migrants' homelessness is characterized by invisibility (Fiedler et al., 2006; Klodawsky, 2006). Thus, one can infer that women migrants' experiences of homelessness are influenced by both gender and migration status, that the intersectional factors shaping migrant women's lives make them that much more vulnerable to housing instability and vulnerability to absolute homelessness, and disproportionate time is spent in unsuitable, unstable and unsafe housing conditions.

Migrant women experience vulnerabilities both similar to Canadian-born women and unique from them. Similarities include: going through a major life event, domestic violence, absolute poverty, mental or physical health problems, exploitive relationships, housing discrimination and loss of employment (Walsh et al., 2011). Differences emerge when, due to migrant status, newcomer women experience specific structural barriers to housing access, including: discrimination (Conseil des Montréalaises, 2006; Rose and Charrette, 2011), inability to afford safe housing for financial reasons (Deacon & Sullivan, 2009), lack of knowledge about their rights and about how to find appropriate housing (Canada Mortgage and Housing Corporation, 2007; Conseil des Montréalaises, 2006), language barriers (Conseil des Montréalaises, 2006; Hiebert, et al., 2005; Martin, 2004; Murdie, 2008; Rose and Charrette, 2011), lack of a guarantor or references (Rose, & Charrette, 2011), and in some cases, ineligibility for services (Walsh et al., 2011). Migrant women's housing status may also be influenced by factors such as a traumatic migration trajectory (Gerard and Pickering, 2013), fear of losing status or being deported (Walsh et al., 2011), the physical and psychological consequences of experiencing trafficking (Miller, Decker, Silverman, and Raj, 2007; Ottisova et

al., 2016), and migrant-specific financial constraints, such as the need to send remittances to countries of origin (Ives et al., 2014).

When compared to the housing vulnerabilities experienced by male migrants, women's gender enhances their vulnerability to homelessness and poor housing status. Women migrants experience similar barriers to migrant men such as low income, language difficulty and not understanding the housing market and their rights (Chiu, et al., 2009; Murdie, 2008), though housing security is also impacted by certain gender-related factors. One study in Toronto found that absolute homelessness among non-status migrant women was highly connected to pregnancy among other gender-specific conditions (Paradis et al., 2009). At least two other studies have noted the connection between intimate partner violence and migrant women's homelessness (Hiebert et al., 2005; Thurston et al., 2006). Walsh et al. (2011) have further posited that migrant women's greater responsibility for childcare has left them at higher risk of homelessness than migrant men, because of limitations that caring for children places on one's potential to participate in the income-generating activities required to obtain and sustain stable housing conditions.

Health of migrant women

Bierman, Ahmad, and Mawani (2009) proposed a framework for understanding migrant women's health that includes four areas of inquiry: social determinants of health (Raphael, 2009), gender equity, racial/ethnic disparities in health, and the migration experience. Myriad studies have examined migrants' deteriorating health in relation to their socioeconomic status and other social determinants of health (Bierman et al., 2009; Boyd and Yiu, 2009; Guruge and Collins, 2008; Hyman, 2011; Kinnon, 1999; MacKinnon and Howard, 2000). If one is unsheltered, emergency sheltered, provisionally accommodated, or at risk of homelessness

(Gaetz et al., 2013), one is at greater risk for physical injuries, mental health problems, family conflict, communicable infectious diseases, and interpersonal violence (Baker et al., 2010; Statistics Canada, 2006). A significant body of work has focused on the gendered experiences of migration, illustrating the critical ways that women's experiences differ from those of men along the migration trajectory. Initial decision-making regarding how, when and why to leave one's country of origin (Hoang, 2011), norms and values around gendered roles along the migration route and once in the country of settlement, and divergent experiences and opportunities compose the context of women's migration (Hondagneu-Sotelo, 1994; Pugh, 2018), and, in turn, shape their physical, mental, and emotional health. Structural racism, including negative attitudes towards migrants by health care provides, also influences access to health care (Hankivsky and Christoffersen, 2008; Rousseau et al., 2017; Veenstra, 2009). When migration status is added at the intersection of multiple social determinants of health, health status vulnerability increases (Oxman-Martinez et al., 2005; Rousseau et al., 2013; Sikka et al., 2011). Immigration status may enable or block access to health services (Hennebry, McLaughlin and Preibisch, 2016). Increasing women's vulnerability, women are represented disproportionately higher in more precarious migration statuses (Oxman-Martinez et al., 2005; Rousseau et al., 2013; Sikka et al., 2011).

In general, persons voluntarily migrating to Canada appear healthier than the Canadian-born population (Chen et al., 1996; Kinnon, 1999). This is frequently referred to as "the healthy immigrant effect", the effect of immigration policies selecting individuals in good health to come to Canada. This difference tends to disappear within the first 5-10 years of settlement in Canada, notably among non-European immigrants and women (Newbold, 2010; Chen et al., 1996; Spitzer, 2011). Employment, income distribution, social exclusion and health services have been

advanced to explain the observed deterioration in health. It is perhaps not surprising to note that migrant women experience a decline in health status upon arrival to Canada. Migrant women earn less, on average, than Canadian-born women and men, and racialized women are among the populations most at-risk of having low incomes (Boyd and Yiu, 2009). In general, immigrants have a higher incidence of poverty and dependence on social assistance, despite having higher levels of education (Omidvar and Richmond, 2003).

Access to health services has also been highlighted as a major factor contributing to declining health. Migrant-specific barriers to health service access include: limited or no language proficiency in English or French, lack of coverage or eligibility for services, lack of culturally appropriate services or culturally safe providers, lack of understanding about how the health system works and not knowing what services are available (Bierman et al., 2009; MacKinnon and Howard, 2000; Magalhaes et al., 2010; Spitzer, 2011). Consequently, migrants have a tendency to underuse health services (Guruge et al., 2000) and may therefore lack preventative health care and/or experience illness that goes untreated (Oxman-Martinez et al., 2005). Pregnancy and childbirth is also a particular area of exclusion and risk for migrant women, particularly those with precarious immigration status (Khanlou et al., 2017; Vanthuyne et al., 2013; Ricard-Guay et al., 2014).

Health and homelessness of women

With the exception of Newbold (2010), who points out that housing facilitates good health and that poor health can lead to homelessness, there is a great silence in the literature on the interaction between housing status and health among migrants or concerning womens' health

and housing status. This is despite a strong knowledge base linking poor housing to poor health in the general population (Bryant, 2009; Shapcott, 2009).

Although women experiencing absolute homelessness represent a minority among women with poor housing status in Canada, these women illustrate how homelessness is detrimental to one's health (Frankish et al., 2005). Cheung and Hwang (2004), for example, found that homeless women in Toronto aged 18-44 are at 10 times greater risk of premature death than women in the general population. Gessler, Maes, and Skelton (2011) showed that homeless women in Winnipeg have significantly higher rates of epilepsy, heart attacks, angina, diabetes, and migraine headaches than women in the general population. Exhaustion, reduced personal hygiene, hunger, poor nutrition, poor dental hygiene, sleep disorders, social isolation, and experiences of violence and/or sexual assault were also identified (Watson, Crawley & Kane, 2016). Homeless women are 10 times more likely to be victims of sexual assault and twice as likely to have received a mental health diagnosis than homeless men (Khandor and Mason, 2008). Similarly, a study of homeless women in Toronto found statistically significant higher rates of arthritis/rheumatism, allergies, liver disease, migraines, asthma, chronic obstructive pulmonary disease, stomach/intestinal ulcers, heart disease, and diabetes (Khandor and Mason, 2008).

METHODS

This article reports on the health-related findings of a Montreal-based study[2] designed around the idea that housing insecurity and migration are gendered phenomena (Walsh et al.,

[2] 2010-2011. *Blinded*. HRSDC Homelessness Partnering Strategy, Homelessness Knowledge Development Grant. $20,000.

2009) and that the direct experiences of persons with insecure housing should be heard to inform solutions (Acosto & Toro, 2001; Walsh et al., 2010). An exploratory, qualitative methodological approach was adopted (Padgett, 2016), using a broad definition of housing insecurity: from absolute homelessness (e.g., residing rough), to invisible homelessness (e.g., couch surfing) to those at risk of homelessness (e.g., housing unaffordability; Ben Soltane et al., 2012; Echenberg and Jensen 2008). Researchers also integrated a feminist qualitative approach (Hesse-Biber and Leavy, 2007, p.113), wanting to access "the subjugated knowledge of the diversity of women's realities that often lie hidden and unarticulated" thus naming the study Uncovering Invisibilities, and being aware of our position and power in relation to our study participants.

Following institutional ethics approval and after providing informed consent, 26 adult newcomer women (ranging in age from 20-65, with many in their 30s) were recruited in Montreal, Canada. 'Newcomer' was defined as foreign-born women who came to live in Canada during the previous 10 years, regardless of their immigration status. Women were recruited directly through advertisements in public places and in collaboration with community organizations (women's centers, homeless shelters, crisis centers, domestic violence shelters, immigrant settlement agencies and ethnic associations) and they self-identified as having experienced housing insecurity. Efforts were made to include a diversity of immigrant statuses -- permanent residents, temporary foreign workers, refugee claimants and undocumented women – as well as diversity in ethnicity, race, country of origin, family composition, sexual orientation, age, and range of physical and mental ability. Women were engaged in semi-structured, open-ended interviews lasting approximately one hour. Interviews were conducted in English or French in a location and time of participants' choosing. Participants were reimbursed for travel and childcare expenses related to the interview and were given a small honorarium for

participation. Interview questions focused on five themes: (1) current demographics and immigration history, (2) current health and well-being, (3) history of housing and home insecurity, (4) current housing situation, and (5) survival strategies.

In addition, five key informants working in four local women's shelters participated in semi-structured, open-ended interviews designed to gather information about newcomer women's homelessness or housing insecurity from a service provider's perspective and best practices and challenges in serving the target population. All interviews were transcribed, coded with NVIVO software and then analyzed using the constant comparative method (Dye et al., 2000), exploring themes related to gendered experience, migration status, migration trajectory, racialized identity, and housing.

FINDINGS: THE COMPLEX ROLE OF HEALTH IN THE HOUSING INSECURITY OF MIGRANT WOMEN

Our findings clearly revealed three main areas where both health problems and access to health significantly influence migrant women's experiences of housing insecurity. First, similar to all women in Canada facing housing insecurity, health problems perpetuated, indirectly and directly, housing insecurity and homelessness. Second, challenges related specifically to their immigration status contributed to women's health problems and housing insecurity. Third, women developed a range of health preservation and coping strategies to negotiate the risks associated with the intersections of health, housing insecurity and immigration.

Health as a factor leading women to fall into housing insecurity and homelessness…

Most participants reported health problems including: migraine headaches, abdominal pain, anemia, high blood pressure, persistent coughs and colds, fevers, and fatigue. Reproductive health issues also featured prominently with one woman reporting fibroids and three others reporting recent pregnancies, one of which involved premature labour and delivery and another which included gestational diabetes. Most women were unaware of the potential relationship between housing insecurity and health, although three participants explicitly referred to poor health as a direct cause of their precarious housing situations. One woman had been in a disabling car accident, was unable to work and therefore unable to maintain her housing. Another's vision problems, resulting from an injury, prevented her from working and ultimately led to her housing instability. A third participant discussed at length the challenges that she and her husband went through to maintain an adequate income and stable housing while she was pregnant and caring for a newborn while her husband was going through cancer treatment.

> I had to give the baby just breast milk in order to save money to run the house. My husband was really sick; he would go in and out of the hospital. He began chemotherapy 3 months after his operation. The chemo was $1,800, and the government was covering a half of that.

Her caregiving responsibilities and the high costs of her husband's treatment (not fully covered by public Medicare, as we will address below) kept this participant from being able to obtain a housing that was stable and safe for her family. Notably, none of the women in our study spoke of substance abuse or addictions as a health issue that contributed to their situation.

… and health as a factor keeping them there

Although health problems were not necessarily seen as the key factor for our participants' falling into housing insecurity and homelessness, most women expressed that their precarious

housing status had the effect of introducing new stress, mental health problems, and illness into their lives. One participant noted, "Oh, yeah. I was really stressed. I was always asking myself where I was going to go." Another spoke of how her housing insecurity made her feel especially emotionally vulnerable while pregnant:

> About my health? Well, I can say that the situation really affected my morale. I was even afraid that all this would hurt my baby. In terms of morale, I was not doing well. I was not doing well at all.

Participants clearly identified that their precarious housing status detrimentally affected their health. One women shared how homelessness had contributed to her chronic pain and fatigue, another spoke of an enduring burning in her chest, while another blamed the stress of housing precarity for complications in her pregnancy and delivery. Another woman elucidated the link between her housing stress and her chronic eye problems:

> One eye almost loses vision. It's very serious… It's because of the stress hormone… It's a break in the balance between those hormones and so it affects my eyes… A lot of flashes, and it's very dark, and I feel headache and sick. I found it's a pattern that every time I experience crisis, it will happen.

Another participant linked the stress related to housing insecurity and homelessness to a host of health difficulties:

> I had… fibroids. Doctors say they tend to grow because of stress. I don't know, but sometimes when you are under a lot of stress, the hormones become unbalanced. Especially during that time, I was under a lot of stress. Because it was painful, well, my doctor told me that from time to time, my hemoglobin was low. That also could be related to stress because I didn't eat well. And also, I had thyroid disorder. And actually, the doctor told me that; I was under so much stress.

Such high levels of stress and such serious health concerns left our participants unable to work or to take measures to improve their housing situations.

Health challenges specific to (im)migrant women

Migrant women can experience health problems that can tip them into housing insecurity or homelessness, as is true for any woman in Canada. However, participants' stories revealed that their status as a migrant placed them in a particularly precarious situation. The first order of difficulty is systemic. Immigration status is a key determinant of eligibility for health insurance. The second order of difficulty is more individual, with some women suffering physical or mental health challenges related to their migration experiences. They may be far from their families and socially isolated and they are often unfamiliar with the Canadian healthcare system.

Ineligibility for public health insurance

Provincial Medicare uses immigration status as one of the primary determinants of eligibility for public health insurance. While migrants with permanent status (permanent residents, temporary foreign workers) are accorded coverage in Quebec after a 3-month waiting period, other with precarious statuses (undocumented, students, those temporary awaiting sponsorship or decisions on other applications) are excluded.

Participants expressed that access to healthcare was very important. One woman stated she prioritized getting access to Medicare rather than securing housing when she first arrived in Canada and became a permanent resident, but it was far from easy:

> The first thing I went to deal with was the Medicare card. Because I was pregnant, I was like, "Okay, health is primary and I need this Medicare card because I need to go to the hospital to find a doctor." This is still not easy to do in Quebec, but I need to ensure that the baby and I both are okay. So, health was primary, housing was secondary.

Our participants reported that being ineligible for Medicare made it difficult or impossible to consult with medical professionals; they were often unable to afford the cash

payments required. This is exemplified by one participant's need for medical attention but not being able to consult:

> Q: Ok, you haven't been to a doctor since you came to Canada? Have you had trouble with stomach or head or any other kind of things?
> A: I was supposed to go a doctor but I don't go. My head and my stomach… Sometime I have these migraine headaches. They last like two days sometimes. And sometimes when I get my period I have this belly pain and stuff like that…
> Q: So what do you do to take care of yourself?
> A: Take some pain pills.

Even when women were eligible, it could be very difficult to actually obtain a Medicare card. Sometimes, women's lives were chaotic, making it difficult to organize themselves to complete an application. Other times, there were significant bureaucratic barriers. After having been in Canada a few years, one participant experienced a bout of absolute homelessness, during which time her Medicare card expired. Getting a new card when she was pregnant again proved extremely difficult:

> Sometimes you just fall on a bad agent, who just isn't going to give an inch. And that was the agent that I got. She got me being 5 months pregnant, not having experience in winter with this baby. It took three years to run all over Montreal to collect documents. I had no documents left, when I returned, everything that I had owned had vanished.

The usual requests for documents were made more complicated for her because of having lost all her belongings (including her immigration documents) while being homeless.

Fear that health will be a barrier to permanent immigration

Another health concern unique to migrant women is the real possibility that documentation of any health problems may work against them when they apply for permanent residency; this due to a longstanding policy of Canadian immigration. Applicants for permanent residency can be refused on health grounds if their condition "is likely to be a danger to public

health or public safety, or might reasonably be expected to cause excessive demand on health or social services", as evaluated by immigration officers (Government of Canada, 2013). However, people who have come as refugees or have humanitarian status are exempt from this rule. While it takes a rather serious health problem to reach this monetary threshold (diabetes or high blood pressure, for example, would not be a barrier), it creates a great deal of anxiety for people hoping to obtain permanent status. One woman talked about the importance of health status for her immigration application and the difficulty of maintaining good health while experiencing housing insecurity:

> Especially with changes in the weather, and sometimes especially if you don't have enough clothes, sometimes you catch the cold… But the problem that I experienced, the abdominal, was only when I am adjusting and it's not serious… When I ask for the record, because I give the file to immigration, I need to make it clear that… I'm fit to work in Canada. I'm not a "sick person." So I ask for that record, I submit it to immigration.

Language and cultural barriers to the health system

Women born in Canada overwhelmingly speak one of the official languages and have at least a nominal familiarity with the health system. These two things are not a given for migrant women, however. Even when they do speak English or French and understand the basic structure and procedures of the Canadian health system, they may experience a cultural disconnect from health services or be confronted with direct discrimination or racism. One participant shared how language difficulties affected her level of comfort in seeking medical help:

> A: Sometimes when I'm alone in the house, I can't sleep.
> Q: Have you ever seen a doctor about that?
> A: No. But I haven't tried. I feel like if I go there, they'll just tell me I'm fat. Let me tell you something: I went to the community clinic and the person was nice. I told her that if she spoke slowly, I'd understand. So she did. But when I saw the doctor, he spoke a lot and I couldn't understand what he said… So I feel like, if I go to the

> doctor, I have to speak well because he doesn't have time to listen to me. I just don't want to be alone. I feel alone, isolated (crying)…

Of note, however, is that language did not emerge as one of the priority concerns of the women we interviewed. While lack of language proficiency made access more challenging for them, participants put the emphasis on how social barriers – such as classism or racism – intersected to contribute to poor health experiences.

Family separation, social isolation and lack of support in times of health crisis

Oftentimes, women draw on social supports as a protective factor in the face of health concerns or stress. However, for migrant women with housing insecurity, these supports were either not present or not adequate to meet the level of need when a health crisis occurred. When migrant women are separated from their families and become ill, there is often limited to no support system to assist with caregiving, household upkeep, and economic wellbeing. Many of our research participants also voiced the lack of support of family, with spouses, parents and siblings remaining behind in their countries of origin for economic, immigration and/or health reasons.

For participants who had social connections in Montreal, there were concerns about jeopardizing the quality of life and relationships with those with whom they were able to stay. One participant recalled her difficulties when her husband had been diagnosed with terminal cancer before he became eligible for any Medicare and was unable to work. A friend had invited them to stay with her, her husband, and their infant in their small apartment.

> My friend's husband was just struggling to survive too. He did not have a job and my friend was often home with the child. Her husband was working in one factory, he was getting minimum wage but then he lost the job before we arrived. It was not easy, and my husband was not working (because of his cancer) so they were basically feeding us in

> their home with their meagre income they had. We understood because they were barely surviving, and especially that we did not have anything to contribute once our food ran out, so we just had to survive.

In this case, even though our participant had a small network of friends, the burden of her husband's serious illness, his caregiving needs and their lack of income became too much for their hosts to take on. She felt ashamed and experienced great stress related to her housing situation.

Health care strategies

In the face of health challenges and the limited financial resources to address them, women and shelter workers adapted both innovative and time-tested strategies in order to cope. On a personal level, many women spoke of a personal faith in God and prayer. As one women described:

> Because I had a fever and everything, I was scared. I wanted to see a doctor… They took my blood pressure and it was high. The doctor even seemed a little frightened. Of course it's related to that (the housing problems). I never had blood pressure problems. So I went home and, since I pray, I prayed. And the next appointment, my blood pressure problems were gone.

For another participant, prayer did not exclude the use of medicine, though her personal faith was a source of hope and comfort:

> At times I ask myself, if I fall sick, how will my kids fair, I mean, what would happen to my kids? But I don't let that bother me because I know, God will take care of us, I mean, somehow, somewhere, he will take care of us. But, I have got this far, I haven't been hospitalized. I feel tired most of the time. I feel pain for 24/7 and I take Tylenols almost on a daily basis.

Advice and support from friends

Women who did have a social network drew on this resource to seek advice concerning survival strategies as well as to share personal stress. The two quotes below summarize this poignantly:

> Without friends, there is no information, there is no shared relationship. Friends help me a lot because they know of places that can help me.
>
> Well, I was stressed. But because when I have problems I could talk to my friends, I can release the stress. You know when you don't talk about something, it can kill you. So you use your friends as an outlet.

This potential impact of stress on health was noted by a few respondents. The importance of networking and relationships both personal and provided by professionals were key to health maintenance and care.

Personal faith and determination

A personal sense of determination also served as a protective factor in the face of health risks, of doing things on their own. This determination at times was fueled by commitment to children and at times was fueled by cultural and familial identifications:

> Deep down, you know, just the depression whatever. But, even myself when it happens I'm like, no no no no no. God is there. I have to be strong. And now that I have her, it's like, motivates me more to fight, to have, like you know, I have to do this. I have to do that, because she is going to look up to me. I'm the one that she's gonna learn things from and all that stuff so, I have to do it for her.

Women described fighting to move forward, a determination came through in the tone and body language of the women whom we interviewed, data that cannot be communicated through written script.

Accessing local women's homeless shelters

Local shelters were most critical for women who did not have an informal social network to draw on and who were not acquainted with support services. To further understand the services offered, we met with representatives from four local shelters and a local women's day center with the mission of providing advocacy and integration services for immigrant women. These service providers were aware that immigrant women faced unique health challenges due to barriers in access to health care and had minimal knowledge concerning the health care system. In light of this, they adapted their strategies to address these concerns, nurturing women's personal coping strategies and provided additional support services.

Due to funding and space limitations, organizations had to prioritize between approaches, with an ultimate goal of helping women to move on from the shelter:

> What we do is that we offer each woman with an intervention plan. These women are assigned a worker and this worker works with them on their intervention plan. And, of course, it is adapted to the person's need. So what we do is to work on the person's autonomy to the point that when they leave us, even though they are not necessarily fully autonomous, at the point where they can at least live in supervised apartments.

Linking women to relevant services, beyond shelter, was a priority for them. Shelter workers connected women to services at local health centers (CLSCs) and helped them to access Medicare. They also referred women to local organizations such as a local refugee welcome and advocacy center and legal services. Direct clinical services were often available onsite, such as counselling and, in one instance, a volunteer provided massage services.

Shelter workers described different measures taken to provide women with a warm, comfortable and caring environment. Women were provided with welcome kits with hygiene products such as toothbrushes, serviettes, shampoo and soap upon arrival at the shelter. Meals and hot beverages were used as a way to bring women together for conversation, games and simply quiet companionship. On days of severe weather conditions, shelters adapted their

regulations to allow women to spend more time indoors, together. One shelter provides a garden space for women to grow and harvest their own food, inviting women to contribute to menus with home-country recipes:

> They have a garden evey summer. They make tomatoes, and it is amazing how the women come every year and they take responsibility to work on the garden. Gardening, composting, who, they can tell us what to do. These came out of the workshops they got at the resources center. They took training on gardening, composting.

Finally, shelters offered personal development opportunities, providing language classes and training, courses, and written materials to women concerning personal health care, safety, hygiene, nutrition, and cooking with local ingredients:

> But we do have activities based on what is needed in the house… professionals coming to talk to us… We do have those resources for the women as well. Like Police coming in to speak to the women. They talk about security. And retired lawyers talk about legal matters. We have also had practitioners coming in to talk about dental health, women's issues, etc.

Training was also placed in the context of other activities that women enjoyed such as sewing or painting.

DISCUSSION

Migrant women's experiences with housing insecurity demonstrate how the social determinants of gender, migration status/experience, and housing shape health in different ways than for Canadian-born women. Themes that emerged in our research suggest several implications for policy and practice with these determinants at the forefront.

Policy: Health care accessibility and legal status

There were a number of ways that Canadian immigration and health care policies made it more difficult for migrant women to care for their health and access services when in need. To begin, eligibility for Medicare is closely tied to one's immigration status. For many with precarious status (e.g., undocumented, awaiting sponsorship), access to public health insurance is denied without private insurance being a viable alternative. To prevent people being unable to access any form of care, and to prevent the violation of their internationally recognized human rights, Canadian provinces must provide funding for primary, secondary and tertiary institutions to care for the uninsured. A second health policy raised was systematic access to translation services in public health institutions, which in practice is difficult. Providing proper translation would make it easier for migrant women to confront and overcome the additional social barriers encountered in the health care system (Hadziabdic & Hjelm, 2013). Moreover, providing care in a person's mother tongue contributes greatly to the provision of adequate care (Ouimet et al., 2013; Bischoff, 2003). Finally, as has been raised many times, there is a need for ongoing training of health professionals about the migration-related realities of so many of their patients.

Policy: Migration status

Other policy implications that shape migrant women's housing insecurity and health experiences relate to immigration. Those with precarious status expressed two distinct forms of fear: fear of deportation for those without status who worried being identified to immigration officials via the health system; (2) and the fear of the rejection of visa renewals or permanent residency applications on the grounds of "excessive demand" on the health care system. "Excessive demand" is defined in Section 1 of the Immigration and Refugee Protection Regulations (IRPR) as

- a demand on health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination required under paragraph 16(2)(b) of the Immigration and Refugee Protection Act (IRPA), unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or
- a demand on health services or social services that would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely services to Canadian citizens or permanent resident (Government of Canada, 2016).

This immigration-related fear extended into the lives of those with secure status, however, with the potential denial of the future sponsorship of family members being a worry when accessing health care. Women seemed to express a sense that they needed to be "perfect migrants" if they were to achieve immigration security in Canada. For women who are mothers and have migrated and continue to parent, whether their families are in Canada or in their countries of origin, there is tremendous pressure to be neither sick nor homeless. Their responsibilities may not have lessened simply because they are no longer physically present with their families (Brigham, 2015). Therefore, it may be considered essential to keep health records confidential from immigration authorities and to exclude health problems that develop after arriving in Canada from blocking a person's further immigration applications. The Minister of Immigration is also currently studying the elimination of the "excessive demand" provisions in immigration policy, something that would significantly increase migrants' comfort in seeking appropriate health care. Finally, Canadian immigration policy unfairly imposes family separation on many categories of migrants, an exclusion that should be removed. Even those with permanent status often find it difficult to secure visitor visas for family members who want to travel to Canada to offer support when a person is ill. We argue that the need for family support should be a priority reason for granting visitor visas and that they should be granted in a timely manner.

Practice: A holistic approach to migrant women's health care

Holistic approaches to migrant women's health care that shelters and women's day centers from our study have adopted are supported by research. Art therapy, counselling, physical exercise and health behavior strategies, informal health screenings, advocacy for increased health care access, and resource referrals (Connor and Donohue, 2010) are key to women's health care. Included in a holistic approach is the degree to which migrant women feel adherence to a spiritual or religious faith tradition. One's adherence to a religious faith and consequent belief in and reliance on prayer can be a strong protective factor (Bryant-Davis and Wong, 2013). Studies have found substantial religiosity in migrant populations, actively integrating religion and religious faith into their lives in resettlement (Foley and Hodge, 2007; Franz and Ives, 2010). Spiritual practices have been found to improve overall health and well-being in homeless populations (Connor and Donohue, 2010) and it can helpful to provide space for these activities. Holistic approaches such as meditation and/or guided relaxation strategies, including mindfulness, have been identified as effective coping strategies for women who have experienced trauma (Bryant-Davis and Wong, 2013; Follette, Palm, and Pearson, 2006; Kelly and Garland, 2016).

Another protective strategy central to migrant adaptation in a new country are social networks generated by kinship, friendship, or shared national, ethnic, and cultural elements (Ives, 2007). Research has found that the quantity and quality of social relationships can decrease poor health outcomes by acting as a protective factor, supporting positive health behaviours and improving mental health (Yang et al, 2016). The psychological support of family, community members, and informal networks from the country of origin has been found to improve mental

health outcomes among women refugees (Deacon and Sullivan, 2009). A large study of homelessness in Los Angeles, California, found that women were more likely to have relatives in their social networks (Winetrobe et al., 2017); another American study found that being able to rely on relatives improved housing stability (Calsyn and Winter, 2002). Social networks also decrease stress levels which in turn reduce the intensity and likelihood of poor mental health outcomes for refugees in resettlement (Rousseau et al., 1998; Valtonen, 2012). However, social networks are not always innocuous; our study found that, in some cases, accessing these networks actually put women in physical danger. For example, women in our study reported situations where they were exploited by fellow expatriates.

As our results indicate, the immigrant women with whom we spoke were resourceful, determined, competent and innovative in seeking solutions to their health concerns. However, the services that shelters and women and refugee advocacy organizations offered were either underdeveloped or in a state of precarity due to funding limitations. The women in our study did not have patterns of chronic homelessness or dependency but were momentarily in extremely vulnerable situations due to life circumstances. Funding for holistic approaches to health care in certain shelters and day centers will prevent women from developing chronic illness conditions and will fortify women's capacity to sustain personal health practices.

CONCLUSION

In this paper, we have shared the ways in which health concerns intersect with housing insecurity and homelessness for migrant women with a variety of immigration statuses. As we have noted, health is a major issue that leads to immigrant women's vulnerability to housing insecurity and homelessness whether it causes the problem or whether it limits women's ability

to escape poor housing situations. While health is a factor for many Canadian-born women facing housing insecurity and homelessness, we have shown how the dynamics of this interrelationship play out differently for migrant women due to either their immigration status or their social location. Our research strongly suggests the need for improving access to health care for migrant women through such measures as increasing eligibility for Medicare for women with precarious status (and ultimately ensuring healthcare for all, regardless of status) and improving interpretation and culturally appropriate health care provision.

At the same time, we want to underline the many strategies that migrant women and women's shelters and centers employ to protect their health in the first place, and to address poor health when it does occur. Not always able to count on the public healthcare system to provide them with the care they require, women and service providers have shared their skills in self-care, resource mobilization, programming and networking.

While we feel it unjust that migrant women must rely more heavily on such strategies than Canadian-born women to protect their health and, ultimately, their housing, we admired their work. It is imperative for housing and homelessness agencies to improve their understanding of how migrant women experiencing homeless cope with homelessness so that these agencies can better support them in their efforts to protect their own health and wellbeing and passage to a more secure future.

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