Master of Public Health

Master de Santé Publique

Development of participant recruitment strategy in the project "How to improve health and access to health care of migrants without medical coverage in Montreal"

- the case of the Chinese community

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MPH EHESP 2014-2016

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Acknowledgements

I would first like to thank my thesis professional advisor, Professor Valéry RIDDE of the School of Public Health of the University of Montreal, and my thesis academic advisor, Professor William SHERLAW of EHESP French school of public health. They were always replying my e-mails whenever I ran into trouble or had questions about my research or writing. They consistently allowed this paper to be my own work but steered me in the right the direction whenever they thought I needed it.

I would also like to thank Magalie BENOÎT, the coordinator of the research project. She was helping me to be involved in each step of the project by providing me necessary enriching resources for writing this thesis.

I must thank Professor Martine BELLANGER, the director of the Master of Public Health in EHESP French school of public health. She was not only supervising the whole process of the internship and the writing of the thesis. But more importantly, she was encouraging me by providing me passionate input and validating my work results. I am gratefully indebted to her valuable advice and her stimulating through the entire Master's program.

I would also like to acknowledge Professor Eric BRETON of EHESP French school of public health. He helped me to get this precious research experience in Institute of Public Health Research of University of Montreal (IRSPUM). I would say thanks to Jessika HUARD, Linda FRANCOIS, Magloire BANZADIO, Anne ROCHER, Guiying WANG, who were always available for discussions and provided help in logistic necessities.

Finally, I must express my very profound gratitude to my parents and to my soulmate and love for providing me with unfailing support and continuous encouragement throughout my years of study and through the process of researching and writing this thesis. This accomplishment would not have been possible without them. Thank you.

Table of contents

List of Acronyms

MSAM- FR: Migrants sans assurance médicale; EN: Migrants without health coverage

PFSI- FR:Programme fédéral de santé intérimaire; EN: Interim Federal Health Program

RAMQ- FR: Régie de l'assurance maladie du Québec; EN: Quebec Health Insurance Board

GIS- FR: Système d'information géographic; EN: Geographic information system

UHC- FR: La couverture de santé universelle; EN: Universal health coverage

SDH- FR: Déterminants sociaux de la santé; EN: Social determinants of health

Abstract

Background: Universal Health Coverage (UHC) provides access to key health interventions for all at an affordable cost for achieving equity in health. Nevertheless, it is also a source of health inequity. In fact, it offers a benefits package including financial protection for people. For immigrants arrived in the province of Quebec, Canada, most types of their visa do not allow them to have access to provincial health insurance programs. They need to opt for private insurance to cover health risks. Some immigrants cannot pay or do not have any valid private insurance. Therefore, they become excluded from any financial health protection. In the fist stage of the research project “How to improve health and access to healthcare of immigrants without health insurance in Montreal”, a quantitative survey will be conducted for recruiting 400 immigrants in their communities.

Objective: This paper proposes a respondent recruitment strategy for the project by using the case of the Chinese community in Montreal.

Methods: A conceptual framework and a logic model were used for organizing the works that have been done for the strategy development process. Cultural validation of survey tools and design of communication campaign were used for reducing recruitment barriers and adding incentives. Qualitative analysis was used for understanding migratory profiles and organizations regarding research question. Geographic information system method has been used for understanding the distribution of the target population and for gathering information on places of their activities and organizations.

Results: Key features of the preliminary strategy include: Considering the dimensions of heterogeneity of the target population and addressing these in sampling; Adopting a multiple pathways recruitment approach and an operational plan; Addressing barriers to recruitment and add incentives for participants.

Conclusion: The strategy proposed in this paper considered the heterogeneity of the target population of which no registry, prevalence, and distribution information exist. With multiple recruitment pathways, communication campaign and cultural adaptation, it theoretically allows attaining a relatively good response rate with valid results.

Résumé

Contexte : La couverture sanitaire universelle couvre l'accès aux interventions sanitaires des citoyens à des coûts accessibles permettant de respecter le principe d'équité à la santé. Néanmoins, force est de constater qu'elle se révèle aussi être une source d'iniquités. En effet, elle permet un accès aux soins primaires de santé « benefit package » aux citoyens, et ceux vivant dans des conditions les plus précaires, couvrant les frais financiers associés. Pour les migrants arrivés dans la province du Québec au Canada, la plupart des types de visa ne leur permettent pas d'avoir l'accès aux programmes gouvernementaux d'assurance médicale. Ils doivent donc recourir à une assurance privée pour couvrir leurs risques sanitaires. Si un immigrant ne peut pas payer une assurance privée ou qu'elle n'est plus valide, il est exclu de toutes les protections financières de la santé. L'enquête quantitative du projet de recherche « Comment améliorer la santé et l'accès aux soins des migrants sans assurance médicale à Montréal », prévoit un recrutement de 400 participants dans leurs communautés.

Objectif : Ce rapport présente la stratégie préliminaire et inédite ainsi que son processus de développement pour le recrutement des participants en utilisant le cas de la communauté chinoise à Montréal.

Méthodes : Un cadre conceptuel et un modèle logique ont été utilisés pour organiser les travaux de développement de la stratégie. Les outils d'enquête et la planification de la campagne de communication ont été validés en respectant les facteurs culturels pour réduire les barrières de recrutement et pour stimuler l'engagement de participation de la population cible L'analyse qualitative est utilisée pour comprendre les profils et les organisations migratoires en considérant la question de recherche : comment et où rejoindre les populations cibles. Le système d'information géographique a été utilisé pour comprendre la répartition par arrondissements de la population cible et pour collecter les informations géographiques liées à la communauté.

Résultats : Les caractéristiques essentielles de la stratégie sont la considération des dimensions d'hétérogénéité de la population cible pour le plan d'échantillonnage ; l'adoption d'une approche de recrutement à voies multiples (*multiple pathways*); la diminution des barrières de recrutement et le renforcement de la mobilisation des participants.

Conclusion : La stratégie proposée dans ce rapport souligne la complexité liée à l'hétérogénéité de la population cible en l'absence de registre des migrants sans assurance médicale, d'études de prévalence et de répartition géographique. Les stratégies mises en œuvre pour le recrutement des participants permettront d'atteindre un taux de réponse satisfaisant et valide.

1. Background

1.1 Health Equity

The health status of people differs from one another. It depends on different social characteristics of the environment where people are born and raised. For instance, people living in the poverty are more likely to be affected by illness and have higher possibility to die prematurely. However, people at higher income levels are more likely touched by some chronic diseases. General saying the lower socioeconomic position is always correlated with worse health. This health difference following a social gradient is called Health Inequality (Michael et al. 2008).

Health inequality in a society can be generated by the unequal distribution of different social determinants of health (SDH) . Those are social gradients, stress, early childhood development, social exclusion, unemployment, social support networks, addiction, availability of health food, availability of healthy transportation, and lastly religion, caste and all the social diversity. They are unequally distributed between and within countries, regions, cities for many reasons. If these imbalances are visible, they can be improved or avoided by reasonable actions. However, the resources used on those actions are somehow unfairly allocated to people, and as a consequence, the imbalanced distribution of SDH still exist or even aggravated. This systematic social injustice in health is called health inequity (Marmot, Wilkinson. 2005; Micheal et al. 2008).

1.2 Health equity with UHC and Health Insurance

Health coverage is one aspect in addressing health the issues of Health inequity. In a global scale, the Sustainable Development Goals (SDGs) is a result of the largest consultation process between United Nations (UN) member countries. It proposed an interlinked, multidimensional and mulch-sectorial framework to embrace health-related considerations. Those include poverty, hunger, food insecurity and malnutrition, environmental protection, quality education, and universal health coverage (UHC) (UN, 2015).

UHC has been defined as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, hereby achieving equity in access”(World Health Assembly, 2005). In terms of operational definition, UHC is a system providing health care and financial protection to all citizens of a country. The system often offers a specified package of social benefits that is accessible for all members of a society. The goals of the package are to providing financial risk protection, improved access to health services, and improved health outcomes (WHO, 2010). For achieving those, a good governance and political commitment, effective

bureaucracies are important attributes. This helps a society to reach a better health and social outcomes than do others at a similar level of income (Balabanova et al. 2013).
More precisely, three key features are identified as the main trajectory toward UHC. The first and also the one related to the context of this paper is the political process to create public programs or regulations with the aim of increasing access to care, improving equity, and pooling financial risks. The second is a concomitant rise in health spending and in it's return, which allows buying more health services for more people. The third is an increase in the proportion of pooled health expenditure rather than out-of-pocket health spending (William et al. 2012).

1.3 UHC as a source of Health inequity

In 1978, Alma-Ata conference called for a universality with the health-for-all goal. If this is achieved, everyone- no matter its economic status, ethnic origin, religious and political affiliation – will benefit from full equal access to health in society (WHO, 2004). In 2012, UN General Assembly resolution addressed that continuing high-level political commitment to the achievement of global health goals(UN, 2012). However, despite those appeals, the universal coverage is recently far more difficult to be the eventual remedy for achieving the finality of equity. On the contrary, the developing a better universal coverage system may in itself be a source of creating further inequalities. Certain mechanisms that exclude people from universal coverage system can even be observed. In Brazil, for instance, studies show that the experience in the country has given rise to an inverse equity Hypothesis. Since new health programs "initially reach those of higher socioeconomic status and only later affect the poor"(Hart,1971; Vicora et al. 2000). The imbalance in the development of universal coverage system between regions is, for example, also a source health inequality. Namely, universal health insurance coverage have been generalized a century or more in much of western Europe. Whereas it remains to be a goal to accomplished in most parts of the developing world (Gwatkin, Ergo. 2011).

Several reasons can explain increasing inequality generated by UHC system. Those includes the differences in social structure, ideology or in the economic development process (Wilensky 1974). Other inequalities observed in universal converge system can be measured in terms of waiting times and receipt of intervention procedures (Rodney, Hill. 2014). If those can be reduced by strong political commitment and improvement in organization, some others can be generated because of the political unwillingness of including some people into the UHC system. Some governments deliberately or passively refuse to grant access to UHC to people living in their territory. The rejected people have different appellations in different context. They can be called “refugees”, “undocumented migrants”, “nomadic people” or those denied birth registration (Kirby et

al. 2010). If the equity of access to healthcare is described as “the just distribution of health care according to need”(Frenz, Vega. 2010), then the exclusion of people according to their migratory status despite their health need is an inequity that is intentional created.

The word “Universal” does not always mean covering every single individual and all health service living a territory. UHC systems in different countries have various population coverage rate and service coverage rate (Nicholson et al. 2015). Another question is the definition of “universal”. In principal, it means a legal obligation to provide health care to all its citizens, with the attention to ensure inclusion of all disadvantaged and excluded groups (Kirby 1999). But who are considered as “all citizens?” and “excluded groups”? The definitions of those two change a lot of things. For instance, France recognizes that all people live within their territory are all eligible to be included in their government-held health coverage system. No matter what administrative status do people have, even for undocumented people (Carde 2009). On the contrary, some countries distinguish people by their migratory status related to their migratory situation.

1.4 UHC and Health insurance in Canadian context

Canada is one of the countries with UHC system. Provincial and territorial governments are responsible for defining how the system works in their territories if their programs adhere to five principles of Canada Health Act: 1) publicly administered; 2) comprehensive in coverage; 3) universal; 4) portable across provinces and 5) accessible (Mossialos et al. 2015). Immigrants represented 20.6% of the total population in Canada (Statistics Canada 2011). The large percentage signifies the importance this population in Canadian UHC system. Immigrants normally detain a residence permit or a visa issued by the government. Some of the types of residence permit allow immigrants to have access to publicly finance health care whereas other types do not. In the province of Quebec, Canada, the two types of public health finance programs are RAMQ (Régie de l'assurance maladie du Québec) and the federal program PFSI (Programme fédéral de santé intérimaire). The eligibility to the programs is related to complex legal regulations. In general, immigrants with Permanent Residence Permit, Closed Work Permit, Student Visa and with scholarship, and the conjoint or dependent (age<18, with parental authority) of immigrants with Permanent Residence Permit or Closed Work Permit are eligible to RAMQ(Légis Québec 2016). For PFSI, only immigrants with refugee's residence permits or with ongoing status clams(asylum seekers) are eligible(Government of Canada 2016). Other immigrants with Visitor's Visa, Student's Visa, Open Work Permit, Super Visa (for elderly family members of foreign workers), immigrants with ongoing permanent residence request(not accepted yet), undocumented immigrants, Canadian children with parents in the previous status, do not have access to public health finance programs. They need to opt for private health insurance for covering their health risks and daily

health needs. However, some of them cannot pay or do not have any valid private insurance for some reason. They, therefore, become totally excluded from publicly financed and private financed healthcare of Canadian Universal Health Coverage system.

1.5 The research project and the focus of the paper

The research project “How to improve health and access to care of uninsured migrants in Montreal” was developed in a 2-year process of collaboration with Doctors of the World Canada, the only organization providing free care to uninsured migrants. The project was financed by the IRSC, for a 3-year period. It aims to understand the health, access to care and social determinants of uninsured migrants with a quantitative questionnaire on health, access to care, housing and working conditions and migration situation and related stress. The questionnaire is to be done with 500 migrants recruited at Médecins du Monde clinic, and 400 migrants recruited in their communities. The other aspect of the project, which will be done in 2017-2018 aims to study health initiatives in Montreal and other main migration cities (Vancouver and Toronto) to understand best practices. After the first stage, a qualitative study including 30 interviews with health professionals and administrators will be conducted. The knowledge, attitudes, and decisions taken by professional associations and the RAMQ in Québec will also be studied using a qualitative method (Ridde et al. 2015).

Sampling plan for this quantitative study project is problematic since the population is heterogeneous and no registry exists. People without insurance are not limited to single migratory status, social status and includes undocumented people. The prevalence is unknown, and their geographic aggregation pattern has not been studied. The aim of this paper is to develop a strategy for recruiting questionnaire participants. The goal is to do sampling as rigorous as possible for covering aspects of the heterogeneity of the target population regarding the research question. Recruitment barriers and cultural validity have also been considered in the strategy. MSAM in Chinese immigrants' community are used as the case for this paper.

2. Methods

A conceptual framework has been elaborated(See figure 1) to analyze firstly, theoretical dimensions of the development of the strategy; secondly, the practical aspects of organizing the daily works done in the project. The conceptual framework gives directions for daily research works so that they can give valid results in regards to theoretical dimensions. For describing features of the framework, it includes a cluster of interrelated but not necessarily inter-defined concepts(Hill,

Hansen. 1960) and assumptions for guiding a pre-theoretical stage work of a social science project (Rodman, 1980). Concerning the research, it can be classified as a frame for organizing working hypothesis and practical ideas (Shield, Rangarajan. 2013). Regarding getting results from practical works, it is an abstract representation, connected to the research project's goal that direct the collection and analysis of data (Shield 2014).

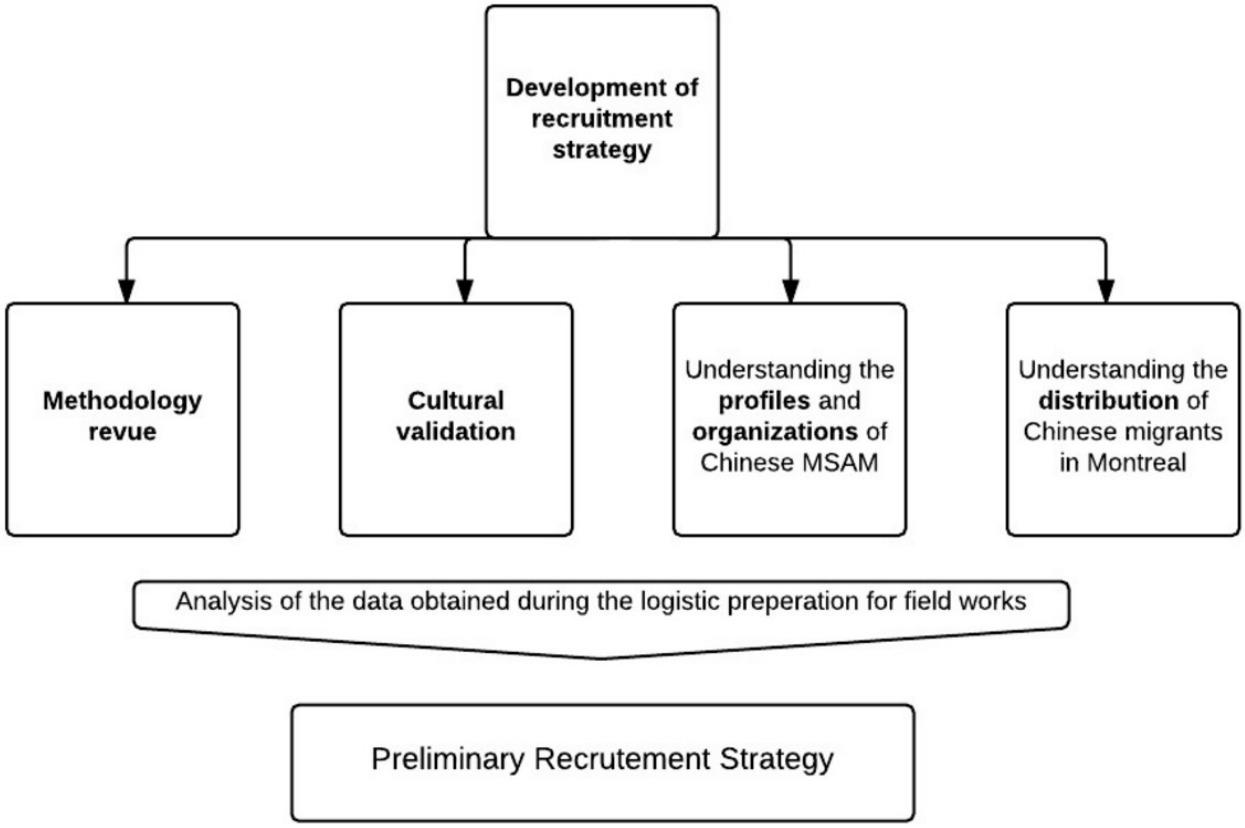

Figure 1. Conceptual framework of MSAM recruitment strategy development

The terms appeared in this model will be explained in details in later parts of this paper. In the following section: “Logic Model”, we will repeat the concepts given in the framework because of their important role of being the fundamental theoretical guideline in the whole strategy development process.

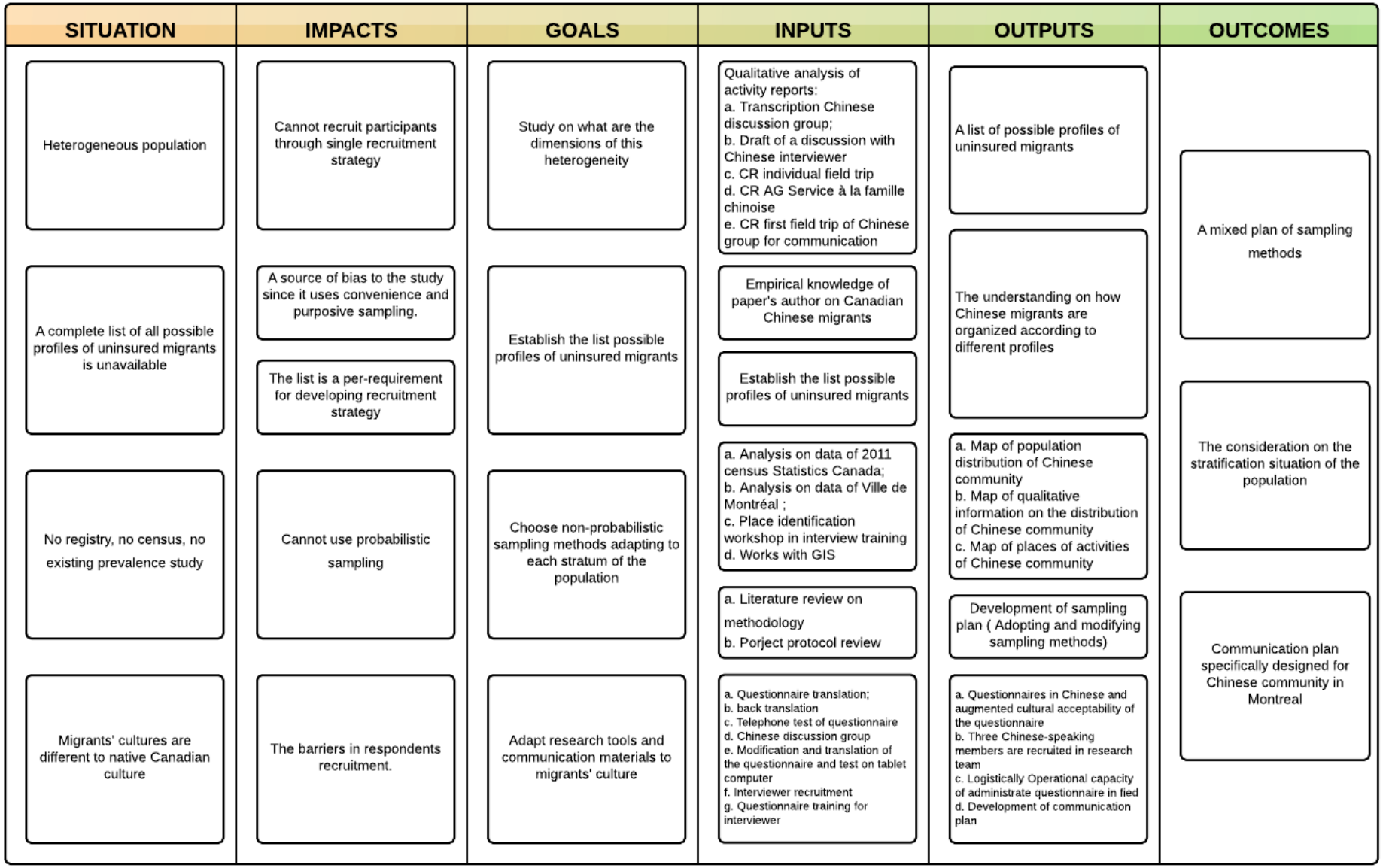

Figure 2. Logic model of MSAM recruitment strategy development

A Logic Model has been conceived (See figure 2) as a tool for managing the practical activities in the recruitment strategy development process(Network, 2007). It has some similar features but has very different use to Conceptual Framework. The latter gives rather broad but comprehensive dimensions which are research questions for recruitment strategy development. A Logic Model enrich those dimensions by adding more details related to daily research activities. It helps to make sure that input resources and the results in all activities are valid and capable of answering the research question identified in Conceptual Framework. Differently to the most used four-components logic model(McCarly, 2001), the one employed in this paper comprise two additional columns: Impacts and Goals.

In the column “Situation”, the context of the development process has been presented. It includes a description of the general feature of the target population and descriptions of operational, technical and cultural restraints for the strategy development. It has been concluded in these four aspects because they can help understanding main challenges and biggest obstacles for the strategy development. In the column “Impact”, the challenges and obstacles are presented. In the column “Goals”, objectives of sub-processes for developing the strategy are given. They have been defined correspondingly to information in previous columns. “Inputs” and “Outputs” can be understood respectively as resources used for each sub-processes and their results. Finally “Outcomes” present expected features of the final recruitment strategy which are developed base on the results of sub-processes. The details of the items in three last columns are mostly given in the Result part of this paper.

Detailed explanations of some terms in the Logic Model can be found in the result part of this paper. Those terms include but not only include: “A source of bias in the study since it uses convenience and purpose sampling”, “The barriers in respondents recruitment” and “The list of possible profiles of uninsured migrants Qualitative analysis of activity reports”.

2.1 Methodology review

The methodology review has been done firstly by examining the protocol of the project to analyze identified recruitment and sampling method. Then a literature review on studies on health of Chinese migrants has been done with following method:

- Objective: Identify recruitment approaches and strategies used for Chinese immigrants population in quantitative health surveys. Determine the methods which are pertinent and can be introduced into the study “Health and access to healthcare of migrants without health insurance in Montreal”
- Type of literature review: A non-comprehensive extended literature review with limited time
- Keywords: Chinese migrants AND health survey
- Period: since 2014
- Result: 172 articles retrieved
- Selection criteria: 1. Exclude articles of which not including any description of respondent recruitment method; of respondent recruitment method; 2. Exclude articles didn't describe any sample source information or sampling method. 3. Exclude articles using existing data and putting concentration on results of analysis.
- Selection result: 8 articles are finally selected.

Box 1. Literature review method used in this paper

2.2 Cultural validation

2.2.1 Questionnaire

We can discuss the cultural validation process of the health-related questionnaire within a completely separated article, so do the process have been done in this project. Here we only study necessary aspects of the validation process for questionnaire translated into Chinese. The questionnaire used in this project is similar to one in an American study on health status and access to health care(Edberg et al. 2011). However, the one that used in our study (see Annexe 4) has been worked out with a theoretical model resulted from the literature review on immigrants' health and with the discussion with regional public health direction. Topics in the questionnaire include Health Status, Psychological Distress, Migratory Stress Scale, Housing Condition, Social Economic Status, Use of Health Service, Access to Care etc. Each section does not have same validity goal. Thus in a rigorous way of thinking, the cultural validation should be done differently, for example, in Housing condition section comparing in Migratory stress scale section. The first one collect only simple information whereas the second one requires test-retest process for assuring it's reliability and validity after being translated. Regarding operational and technical details, the questionnaire is interviewer-administrated. Interviewers use a tablet computer on which the questionnaire is programmed with data processing program ODK (Open Data Kit). All data collected in field will be uploaded and stored in a server. Works have also been done to adapt the form of the questionnaire for its functioning on a tablet computer. Then interviewers test and practice with tablet computers. The questionnaire is validated in 5 languages including Chinese.

Some health-related questionnaires are translated because they are designated to be used in countries where people use the translation target language as the native language(Eremenco et al. 2005). Whereas our questionnaire will be only utilized in Montreal. This point is important because

some terms appeared in the questionnaire cannot be correctly understood, for example by Chinese migrants, if translated in their native language. Those include names of *Arrondissements* in Montreal, names of types of health services, names of types housing etc. Thus the original terms in French are kept after the translation and interviewers are trained to be able to add oral descriptions of them. One important ethical issue is that a respondent, for example, a Chinese migrant, is not obliged to answer a questionnaire in Chinese if it feels confident in its French level (the original language of the questionnaire). A translated questionnaire helps because it avoids the trans-cultural ambitions in complex phrases or in technical and medical terms. And it gives better intuition to the native language speaker when answering questions, especially for psychometric scale parts.

The recently most used translation method for health-related questionnaires is the double-back-translation method (Brislin, 1980). However, it is subject to several limitations (Van de Vijver and Hamble 1996; Harkness 2003; Douglas and Nijssen 2003). Face to those, Douglas 2007 argued that the concept of equivalence need to be reconsidered(Douglas, 2007). More aspects in translation equivalence can be addressed other than linguistic equivalence. Those include Category equivalence, Functional equivalence, and Conceptual equivalence. Box 2 provides a general review of equivalence check in those aspects.

- Category equivalence is mostly related to Social-demographic questions. For example, salaries allowing a person to be considered as middle class differs in Canada and in China. This equivalence is not necessarily pertinent for our questionnaire since it will be only admitted in the Canadian context.
- Functional equivalence refers to questions related to lifestyle and behaviour. In our questionnaire, numbers of words are adjusted in Mandarin to address this aspect especially in the part of Use of health services;
- Conceptual equivalence is the issue raised in attitudinal or abstract questions. In our study, many questions in Migratory stress scale need to be considered with this issue since the scale has no official multicultural versions and lots of words refer the experience of a migrant's living in Canada.

Box 2. Divisions of conceptual equivalence and analysis in context of MSAM study in Montreal

The official Chinese version of Kessler 6 (Kessler, 2005; Yeh et al. 2008)questionnaire has been adopted without any verbal modification. Other response scales and the strength of verbal scales are carefully studied in the Chinese questionnaire. Words have been chosen to ensure that start-points, end-points, and intervals on a scale are equivalent (Mullen 1995).

2.2.2 Discussion group

An advisory committee for questionnaire's cultural validation is useful for including knowledge from researchers, health care professionals, and representatives from other stakeholder organizations (Gagnon et al. 2014). In our project, we did not create a committee in identical way but adopted the idea of discussing the cultural validity of the questionnaire with people having knowledge in different points of view. This has been done through the whole process of our cultural validation. Translated questionnaire were firstly reviewed by people from a Chinese community association. Then a discussion group have been created for telephone test of the questionnaire. A meeting has been organized in which members of the discussion group were giving their feedback on the cultural acceptability of the questionnaire. Moreover, the organizer of the meeting also did a non-structured qualitative interview on the members' perception on the topic of health insurance for migrants in Canada and in Quebec. The transcription of this interview has been re-analyzed in this paper for extracting information on profiles of uninsured Chinese migrants and information on the organization of Chinese migrants in Montreal. Lastly, improvement advises are given by Chinese-speaking interviewers during interviewers' training.

2.2.3 Interviewer recruitment

Two interviewers a recruited among four Chinese-speaking candidates. The selection criteria aim at their working experience with immigrants, experience of social work, their community implication and their capacity of approaching respondents in public places.

2.2.4 Communication approach

Several barriers preventing target population from being involved in our study has been identified in the study protocol(Ridde et al. 2015). The barriers include, for instance, the mistrust of people and especially of undocumented migrants towards the study project; the lack of interest of people on the research topic which means they don't think it is important or being concerned; the unwillingness of giving private information being asked in the questionnaire. Oliver et al. (2008) underlined the importance of public involvement and communication forum in health services research(Oliver et al. 2008). Hanza (2016) suggest that social-cultural appropriate recruitment messages designed by a working group have led to an optimized recruitment goal in a clinical trial for ethnic minorities, immigrants and refugees(Hanza et al. 2016). During the logistical preparation stage of our project, several communication pathways were identified. They were then summarized in the form of a reflexion paper (ZHOU, 2016). In the end of the logistical preparation, a communication committee has been established. Figure 3 presents a framework of elements in the communication approach.

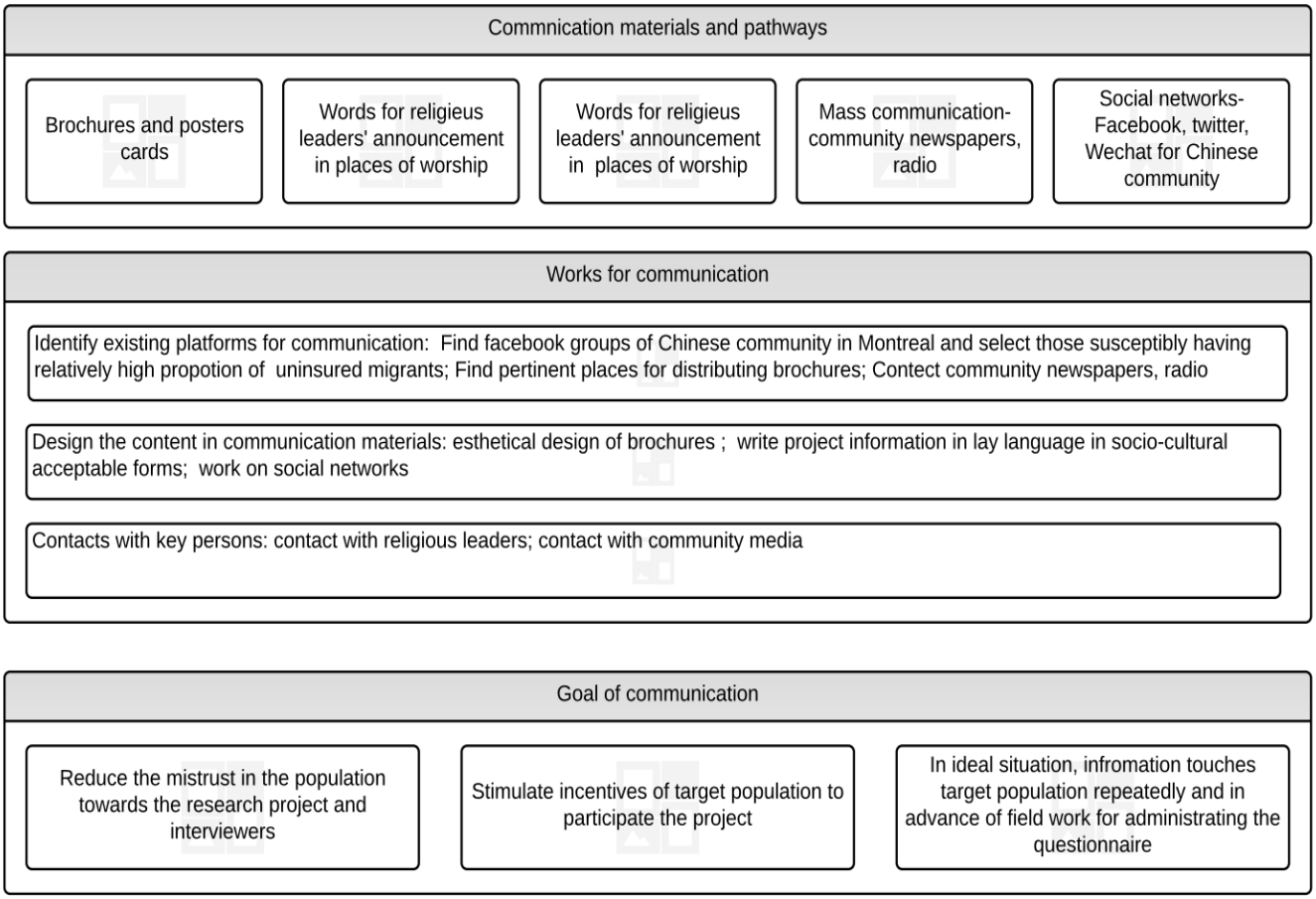

Figure 3. A framework of elements in the communication approach

2.3 Understanding the profiles and organizations of Chines MSAM - Qualitative analysis

2.3.1 Objectives for qualitative analysis

a. Understanding the profiles of Chinese MSAM. This means, first, comprehending their migratory status. What type of residence permit or visa do they have? Because the access to RAMQ and PFSI is strictly related to their migratory status. Second, what are their main reasons for residing in Montreal? What are their main activities in Montreal? This objective corresponds to one of the goals identified in the Logic Model for recruitment strategy development- Establish the list of possible profiles of MASM.

b. Identifying Social networks and social organizations through which more MSAM with similar profiles can be reached.

The two objectives are interrelated because MSAMs' migratory status, main activities and main reasons of residence in Montreal determine which social network or social organization to which they belong. If research team wish to reach a large number of individuals, it can find them

randomly by chance. But the team can do it better in a systematic way, for example, in the first place, get contact with the social network or social organization of those individuals. The difference between network and organization, at least in the context of our study is that a social network is an entity regrouping people who share an essential theme, activity or anything can keep them in day-to-day contact. People in the network can, but do not necessarily, share common geographic, social-economic or other properties. In our project, we may assume that Chinese migrants with limited French and English language skills share migratory information and help each others for administrative processes. Therefore they create a social network organized around this theme. More illustrations are given in the results part of this paper. Social organization means a preexisting organization or association with a working structure. It can be in most cases officially registered with the authorities. For instance, in our project, we have preliminary contact with Service for Chinese Family in Greater Montreal (Service à la famille chinoise à Grand Montréal), and for principally Haitian and Mexican communities, the Solidarity without Boarder (Solidarité sans frontière). Finally, by conducting qualitative studies on MSAMs' profiles, main activities, main reasons for their residence in Montreal, more information will be obtained on networks and organizations through which MSAMs with similar profiles will be joined by the research team. This process may augment the representativeness of our MSAM samples by increasing sample numbers with each profile. Which also explain why establishing the list of possible profiles of MASM is important for our quantitative study, and explain why qualitative study helps increase its representativeness.

2.3.2 Study materials

Study materials used are not originally gathered for targeting questions identified as qualitative study objectives. Daily research activities are conducted for logistic preparation for field work and for research team being acquainted and connected with target population in all aspects. Since the goal of those activities is the same as of the qualitative analysis, information obtained through the daily research activities contains abundant valid qualitative data. Ralph et al. (2014) suggest that “all is data.” Data collection should be “a considered, reflexive undertaking that places data sources such as documents in a continuum rich with purpose, intent, interpretation, and context”(Ralph et al. 2014), which explains why materials listed below have been chosen to be data for qualitative analysis.

The materials include:

1.Transcription of the discussion in Chinese questionnaire test group

During the cultural validation process for questionnaire in the Chinese language, four telephone tests have been conducted. Respondents were then gathering as a discussion group for evaluating the cultural validity and acceptability of the questionnaire. As one step of this process, a short

qualitative study has been conducted. General questions have been asked as a stimulus for initiating a non-structured interview. The questions was “What do you think of the issue of migrants' not being covered by health insurance in Canada” (all respondents are resident in Montreal, therefore with words “in Canada” they can give valid information regarding to situation in Quebec and in Montreal), and, “what do you think about this study?”. 4 telephone test respondents plus the husband of a respondent participated the interview. Conversations are recorded, and the content first 14 minutes of the recording has been transcribed in the Chinese language.

2. Working reports (French: CR- Compte Rendu): CR individual field trip in China town and peripheral areas; CR General Meeting (Fr : Assemblée générale) of organization Service for Chinese Family; Audio CR of first Chinese interviewers' field trip for community communication

3. Informal working materials: Draft map of qualitative distribution of Chinese migrants in Montreal which is a result of discussions with Chinese interviewers

4. The research team and personal knowledge: Those are knowledge obtained besides the works of the development of recruitment strategy. The knowledge includes information obtained from daily conversations between members of research team colleagues, with people in partner organizations, with people without any professional relation in the Chinese community, and information from website, social networks leisure reading without any research purpose. They are transformed into data by using self-interview method. The monolog is recorded. People talks about what and where it has been acknowledged about valid information on the research question.

2.3.3 Analysis Methods

The "Framework" analytic approach that Ritchie J, Spenzer L (2014) proposed originally for Applied Policy Research has been used for synthesizing and interpreting our qualitative data. Under the approach, research questions can be categorized into four categories: Contextual, Diagnostic, Evaluative and strategic. The research question of our analysis can be classified into the first category. The latter include those "identifying the form and nature of what exists. e.g. What are the dimensions of attitudes or perceptions that are held? What is the nature of people's experiences? What needs does the population of the study have? What elements operate within a system?".

The functions of qualitative data in our study according to the "Framework" analytic approach are: Creating typologies and Developing strategies (Ritchie, Spenzer 2014).

The following table shows the working process of the qualitative analysis in this paper.

Nature of the process	"Framework" analytic approach process	Process description
Inductive	Familiarization	Reviewing all qualitative materials for identifying emerging immigrants' profile categories and immigrants' activity and organization categories.
	Identifying Thematic Framework	A second round review of the materials. Definitions and classifications of the categories are highly related to the research questions- how immigrants become uninsured; how and where to reach uninsured immigrants? The experience of the author of the present paper plays an important role in category identification process.
Deductive	Mapping and Interpretation	A selective coding process according to categories identified in the second round review. Overlapping categories were merged with others. Remained categories were justified with extracted qualitative data
Further works	Developing strategies	The preliminary Chinese MSAM recruitment strategy

Table 1. working process of the qualitative analysis

2.4 Understanding the distribution of Chinese MSAM in Montreal

The basic assumption for this analysis is that all populations have their geographic distribution pattern or geographic aggregating pattern. Social-environmental factors, epidemiological factors have all their distribution patterns (Rushton, 2000; Hill, 1965). In the context of this study, the protocol identified the strategy of recruitment by places. Interviewers will be deployed in locations, for instance, of massive affluence of people- metro station, cultural activities, festivals; Chinese grocery stores, humanitarian restaurants, community organizations; places of worship (Ridde et al. 2015). Some of those places were identified during the beginning of fieldwork preparation. Their addresses were gathered. The GIS (Geographic information system) is used in this project is to organize and visualize the identified places on a map of Montreal.

Population Census data combining GIS for understanding population aggregation pattern

No study exist on the prevalence of MSAM in Montreal. However, least information on the distribution of our target population is needed. Thus, the data of population census in 2011 of Statistic Canada has been studied(Statistic Canada, 2011). The census includes information, for instance, numbers of inhabitants born out of Canada, numbers of inhabitants speaking different

mother tongues. The information is organized by *arrondissements* of the city. Combine with GIS mapping, maps can be made, for example, on the density of Migrants by *arrondissements;* density of Chinese-speaking inhabitants by *arrondissements*. However, those maps don't allow us to visualize the density of MSAM or of Chinese-origin immigrants in Montreal. Because no information is available on the prevalence of MASM in among all migrants by *arrondissements.* But they are useful for us to guide sampling, by using for instance Quota sampling.

2.5 Ethical approval

The project received approval from Ethics Committee of the Health Research of University of Montreal(Comité d'éthique de la recherche en satné de l'université de Montréal)

3. Results

This part is firstly about results obtained in different activities that have been done in the development process of respondent recruitment strategy. It will then describe key features of the preliminary strategy developed based on those results. The word “preliminary” means that the strategy has not yet been verified by being applied in field work. Experiences and data accumulated in field work will be later used to feed the development process of an ameliorated strategy. Figure 4 shows phases of the strategy development process.

Figure 4. 3 phases of the strategy development process

3.1 Methodology review

3.1.1 Protocol review

Four recruitment methods have been identified in the study protocol: Venue-based sampling, time

location sampling, respondent driven sampling, and snowball sampling. The protocol included a details review of studies having been done with those methods and with the topic of immigrants' and undocumented immigrants' health and their access to healthcare(Ridde et al. 2015).

3.1.2 Literature review

3.1.2.1 Result of literature review

8 studies (see table 2 and 3) met selection criteria. All studies showed a great variety in terms of study subject, objectives, design, and populations' geographical area. In terms of immigrants' target territory, all of them have been done on Chinese Migrants population in Anglophone regions, which highlights the originality of our study which is being conducted in Francophone region.

Several features of method for recruiting Chinese immigrants are visible in selected studies:

a. Description of recruitment process

Except Dong et al. 2014, the selected studies did not give a comprehensive description on their recruitment process(Dong et al. 2014). A lack of information can be observed on how chosen participants allow achieving a reasonable representativeness of the immigrants population in regard to study question. The representativeness here does not have the same meaning of statistical representativeness but put addresses the level of reflecting the heterogeneity of immigrant's population. This will be explained in the conclusion of the literature review.

b. Social-organizational recruitment approach

5 out of 8 studies created a partnership with community organizations for recruiting immigrants(Dong et al. 2014, Heiniger et al.2015; Lee-Lin et al.2015; Ma et al.2015; Rochelle et al. 2015). One study used online social network specifically used by Chinese immigrants' community of recruiting participants (Hu, Zhang. 2015). Social-organizational recruitment is the main approach used for recruiting immigrant study participants. One study adopted CBPR (Community-based participatory research) approach in the research and established a community advisory board (CAB) with the objective of creating a community-academic partnership(Dong et al. 2014). However this can't be directly considered as a part of participants recruitment strategy since the aim of CBPR is to increase knowledge and understanding on research question by integrating the expertise of community and organizational members (Isreal et al. 2008).

c. Health service recruitment

Afable et al. 2015 used data collected in the end of scheduled clinic appointments; Rochelle et al. 2015 recruited some of their study participants in health centres; Choi et al. 2014 did this at two

private psychological clinics (Afable et al. 2015; Rochelle et al. 2015; Choi et al. 2014).

d. Venue-based approach recruitment

Dong et al. 2014 discussed the possibility of recruiting participants in two segregated urban areas because of the high concentration level of Chinese Migrants in those areas (Dong et al. 2014). This suggests that a venue-based approach or a quasi-venue-based approach may have been considered (venue-based approach: Muhib et al. 2001). The approach has finally not been used in the study. The author argued that the high concentration level could be the result of lower level of acculturation and of the harsh racial sentiment (Dong et al. 2014; Browne, 2010).

e. Sampling methods

All the studies did not use probabilistic sampling method for the entire study population. The sample representativeness of all immigrants in the study area has not been the preoccupation for the studies. Except one study(Dong et al. 2014) discussed the possibility of manipulation census data for the household survey, the method which was finally abandoned for study cost reason. Ma et al. 2015 choose randomly selected 52 out of 111 community organizations for recruitment. However, this randomization does not have exactly the same representative value as probabilistic sampling method in whole immigrants' population. Because the author did not justify how the 111 organizations cover different social, demographic levels of the population (Ma et al. 2015). Lee- Lin et al. 2015 used Randomized Controlled Trial study design. Nevertheless, in the method part of the article, there is no description on how study objects can reflect the heterogeneity of population (Lin et al. 2015).

f. Community Communication

One study recruited 3159 eligible respondents diffused flyers, posters in community centers and published announcement in community newspapers; another study used web-based community social network for communication with immigrants' population (Dong et al. 2014; Hu,Zhang, 2015)

g. Using existing community partnership network

Ma et al. 2015 cooperated with Community Cancer Coalition who identified 111 community organizations in the study area (Ma et al. 2015), which is an efficient way for recruiting participants.

3.1.2.2 Conclusion of literature review -
Single recruitment pathway VS Heterogeneity of immigrants' population

Probabilistic approaches such as household survey have not been used for sampling entire immigrants' population in the selected studies. Cooperation with social organizations is the most

commonly used recruitment pathway. If we define a single recruitment pathway as the process of joining target population through a social structure or virtual social structure such as community centers, clinics, churches, community social networks. The studies choose mostly single pathway for recruitment. This draws attention to the problem of how studies address the heterogeneity of immigrant's population in their sample. Even some studies have chosen more than one type of social organizations (Rochelle et al.2015; Heiniger et al. 2015), authors failed to justify how several social organizations can help reflecting the heterogeneity of immigrants' population in the samples. For conclusion, the author of the present paper suggest that a multiple pathways recruitment strategy is necessary for addressing the heterogeneity issue of immigrant's population. The heterogeneity here is not only about conventional Social Economic Status or Demographic characteristics. It is more related to migratory status and activities and migratory health-related characteristics. Those are specific to research questions. The present paper will address this issue in the following parts.

Study	Article title	Design and objective	Location, population, and time	Sample	Recruitment methods used
Afable et al. 2015	Duration of US Residence and Obesity Risk in NYC Chinese Immigrants	Cross-sectional survey of association between duration of time in the US and obesity risk	New York City, USA; Chinese immigrants	2072 men and women	Convenience sample recruited by the Chinese Community Partnership for Health (CCPH), during clinic appointments; Data collected for the study Chinese American Cardio vescular Healt Assessment (CHA CHA)
Dong et al. 2014	Study design and implementation of the PINE study	Design and implementation of a population-based study on health of Chinese elderly by addressing multiple barriers in research participation	Chinese community-dwelling older adults aged 60 and above in the Greater Chicago area, IL, USA; Began in July 2011 and completed in June 2013	Out of 3542 eligible Chinese older adults, 3159 areed to the study, with a 91.9% response rate	Community-academic partnership approach guided by Community-based participatory research(CBPR); Study instruments developed with community advisory board(CAB); Abandon survey within households after studying the U.S. Census estimates; Considering segregated and high-concentrated residential pattern and engaging 20 community centres as main recruitment sites; Flyers, posters placed in restaurants, tea-houses, parks; Announcements on community newspapers; Multiple dialects interview; Intensive initial interviewer training and booster trainings.
Hu, Zhang. 2015	Exploring the associated factors of elevated psychological distress in a community residing sample of Australian Chinese migrants	Screen for psychological distress among Australian Chinese migrants and to understand the potential correlates that contribute to elevated psychological distress in the population	Australian Chinese migrants' community; Not limited in defined geographical area	414 participants, 55%female, 45%male	Migrants were recruited through several Australian Chinese community's social websites to complete an online health survey
Rochelle et al. 2015	Using the Theory of Planned Behaviour to Explain Use of Traditional Chinese Medicine among Hong Kong Chinese in Britain	Examination of predictors of Traditional Chinese Medicine (TCM) utilization and satisfaction with TCM under the context of the under-utilisation of western healthcare services by Hong Kong Chinese Migrants	Manchester and London, UK	222 “UK Hong Kong” Chinese	Participants were recruited via local Chinese organization including Chinese community centres, health centres and advice centres

Table 2. Studies met inclusion criteria in which the sample included Chinese immigrants only

Study	Article title	Design and objective	Location, population and time	Sample	Recruitment methods used
Choi et al. 2014	Acceptability of psychological treatment to Chinese-and Caucasian-Australians: Internet treatment reduces barriers but face-to-face care is preferred. Social psychiatry and psychiatric epidemiology	Explore the acceptability of internet psychological treatment	Sydney, Australia; From March to August 2013	289 Chinese, 106 Caucasion	Consecutive patients routinely attending medical practices at two private psychological clinics in Sydney central business district
Heinige r et al. 2015	Fatalism and Health Promoting Behaviours in Chinese and Korean Immigrants and Caucasians	Compare the association of Fatalism with exercise, nutrition pattern and medical screening rate and health behaviors among Chinese , Koreans and Caucasians	Sydney, Australia	105 web-survey participants and 204 participant for paper version questionnaire; 94 Chinese migrants in total.	Participants were recruited through churches, community groups.
Lee-Lin et al. 2015	A breast health educational program for Chinese-American women: 3-to 12-month postintervention effect	Randomized controlled trial for testing the efficacy of Targeted Breast Health Educational Program (TBHEP)	Portland, Oregon, metropolitan area; Foreign-born Chinese women, defined as immigrated to the US and self-identified as Chinese or Chinese American; From April 2010 to September 2011	300 among all recruited Asian-origin participants	Convenience sample recruited from Asian community organizations having 8525 clients
Ma et al. 2015	Hepatitis B screening among Chinese Americans: a structural equation modelling analysis	A cross-sectional study evaluating a heuristic model identifying factors contributing to Hepatitis B(HBV) screening among Chinese Americans	Greater Philadelphia area, New Jersey, and New York City, USA	924 Chinese Americans of which 718 had complete data for final analysis	The study was part of a large study including Chinese, Korean, Vietnamese and Cambodian migrants. 52 organizations were randomly selected with cooperation with a regional Asian Community Cancer Coalition including 111 Asian community organizations. A proportional sampling procedure was adopted based on the size of each group.

Table 3. Studies met inclusion criteria in which the sample included Chinese immigrants and immigrants from other ethnic groups

3.2 Cultural validation

3.2.1 Validation of translated questionnaire

Figure 5 and figure 6 show the classical back translation model proposed by Brislin (1980) and the cultural validation procedures in our project for Chinese questionnaire.

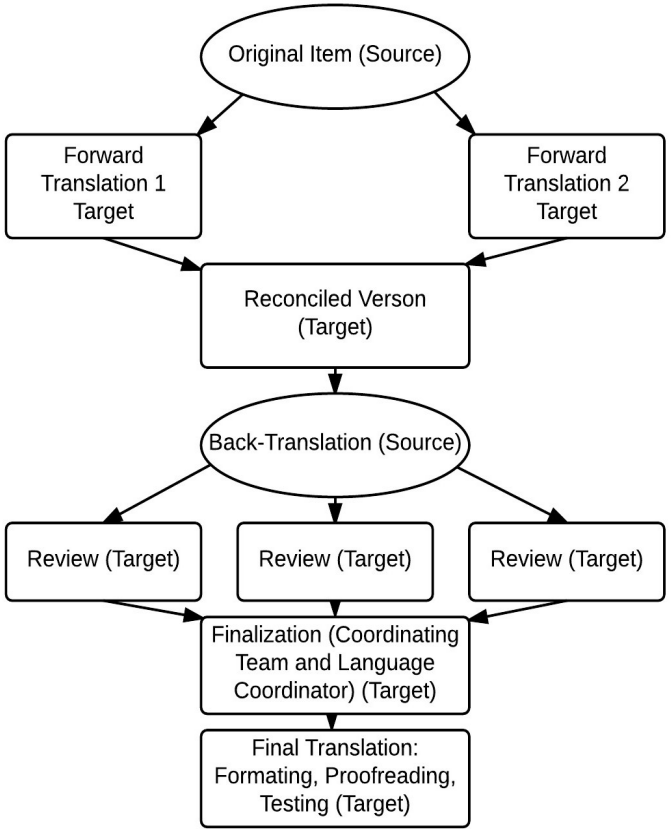

Figure 5. Classical back translation model proposed by Brislin (1980)

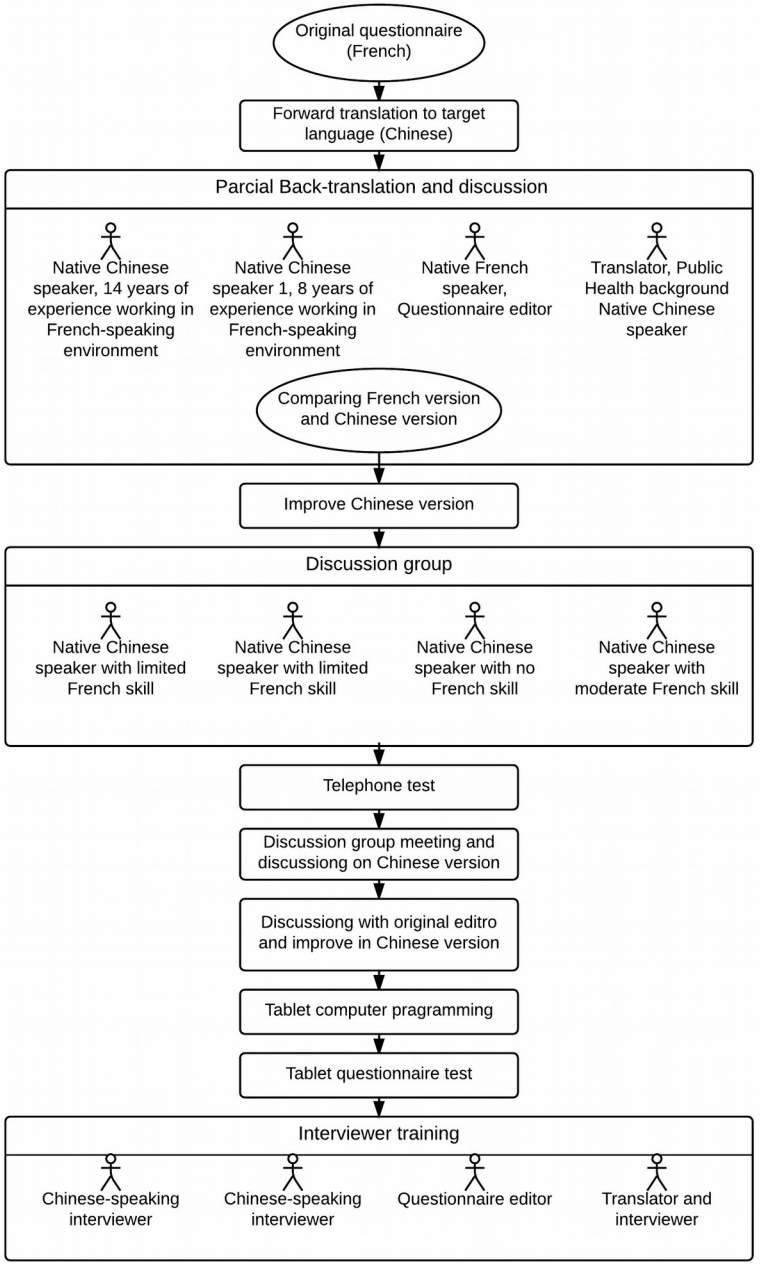

Figure 6. Cultural validation procedures in this paper

The reason why the Brislin's model has not been exactly followed is that we found that the model put most concentration on the degree of equivalence the between back-translated version in original language and the original version of the questionnaire in the original language. The judgement on the equivalence level is given by a reviewer who is a native speaker of the original language of questionnaire. This does not take enough account of a native speaker of the target language, in other words, respondents' evaluation on the equivalence between original version, translated version or/and back-translated version. T

his equivalence degree is, however, most important for assuring linguistic validation of a translated questionnaire. For addressing this issue, the process that we were using included people using the target language as the mother tongue but mastering perfectly the original language of the questionnaire and living the linguistic environment of the original language. We integrated a test step with the target language respondent in the middle of the validation process. Linguistic discrepancies and problematic terms are then discussed between the translator and the French-speaking editor of original questionnaire. Lastly, we found that even between native speakers of the target language, the understandings of specific terms are different. It is hardly possible to make a final target language version which fits linguistic habits of everyone. Especially for Chinese language, linguistic habits and vocabularies vary a lot according to the geographical origin of a person. Therefore, despite the great efforts have been made in cultural validation, we trained interviewer by discussing with them in details the conceptual ideas of all questions in the questionnaire. So that interviewers can give additional valid explanations in case that Chinese-speaking respondent have difficulty in understanding the questions. Through all the process, a more collaborative and iterative translation have been achieved (Douglas, 2007).

3.2.2 Recruited Chinese-speaking interviewers

Field work team include three Chinese-speaking interviewers. Two are recruited, plus the author of the present paper, three interviewers work in recruitment team for Chinese migrants.

3.2.3 Communication

Communication committee is continuing to produce communication materials, diffuse them and contact key stakeholders for creating social, media atmosphere and for the purpose of augmenting participation rate of MSAM in Montreal. Produced materials include: “one pager”- a resume of the project in one page; press release- a newspaper report style article written by committee members having related experience; visit cards; posters. Contacted people editors of include Chinese community newspapers, Chinese consulate in Montreal.

3.3 Understanding the profiles and organizations of Chines MSAM - Result of qualitative analysis

3.3.1 Profiles and sources of Chinese MSAM

a. University students

Montreal has a high concentration of Chinese students in its main universities- Mcgill, Concordia, l'Ecole de technologie supérieure, University of Montreal and University of Quebec in Montreal (Mcintosh, 2016). This trend will be accelerated as Quebec becomes a destination more than more important for Chinese students(Quebec, 2015). In past years, almost half of the students have chosen to remain in Quebec after their studies, which make them an essential source of new Chinese immigrants (Statistic Canada, 2015). As the result of qualitative analysis, we found that this population is a source of MSAM.

"Foreign residents with student visa are not eligible to governmental health coverage package- RAMQ or other health coverage program"

"Canadian law compel foreign students to pay their private health insurance ever year. However because the cost of living and other spendings, some Chinese university student don't renew their health insurance in the second or third university years."

(Self-interview, research team and personal knowledge)

b. Graduated university students changing migratory status

"Chinese students' private health insurance is related to their university programs. When they finished their program the private health insurance is no more valid. At this time, they are with student's visa and without any financial health coverage. Some of them choose to not leave Canada because they want to apply for a foreign temporary worker's visa and find a job."

(Self-interview, research team and personal knowledge)

We separate these immigrants from category "university students" because they have different reasons of being uninsured, different migratory activity, and different recruitment pathways for the study. For instance, uninsured university students could be reached through students' organizations whereas students changing migratory status are less concentrated in student unions.

c. University students' parents

"In nowadays, there are numbers of mothers with temporary visitors' visa (in Canada). All (most) of them don't have a medical card (for governmental health insurance package). I'm acquainted with lots of them. If they get sick, they take medications that they brought from China. But they have the financial assets for a private health insurance, but they just don't pay. Because if they have serious health problems, they can buy right away a return ticket for China (for getting treatment)"

(CR Groupe de discussion en chinois sur questionnaire)

This qualitative datum reveals not only a category of MSAM source but also acknowledge us how the fact of being uninsured acts as a barrier for migrants' primary healthcare needs, even for immigrants with good financial assets. “If they get sick,
they take medications that they brought from China.”; “If they have serious health problems, they can buy right away a return ticket for China”

d. Educational immigrants

Immigrants who settle in Canada especially for integrating their young children into Canadian education system.

“In Chinese people's mind, including me, schooling their children is the most important thing in the life, and sending their children to Canada is a good choice”
(CR Groupe de discussion en chinois sur questionnaire)

“A Chinese family shares a room in the apartment where I live in Montreal. They have a four-year-old daughter. The father is aged 60 and doesn't speak any English or French. The mother is aged 40, speaks French but not that fluent. The only reason why they settled in Canada is to school their daughter here.”
(Self-interview, research team and personal knowledge)

“Nursery schools in China today compete to augment the tuition fee. When I came to Canada(comment: Montreal), I found that the tuition fee here is less expensive than in Beijing.”
(The statement of paper's author's roommate. Self-interview, research team and personal knowledge)

We distinguish those immigrants from the previous category because the migratory activity of schooling a nursery-school age child is not equivalent this of accompanying a university student. And as a result, their migratory social networks could not be the same.

e. Foreign workers' family members

“Foreign workers with open working visa in Canada are not eligible for RAMQ. But they are obliged to pay a private health insurance in their company and their conjoint are covered by the insurance. However, if lose their job or quit the job for seeking for a new job, they could become uninsured”
(CR Groupe de discussion en chinois sur questionnaire)

“Parents or grandparents of foreign workers with Open Working Visa can reside in Canada with Super visa(a type of visa). They are not eligible for RAMQ and they are not necessary covered by private health insurance that children paid in company”
(Self-interview, research team and personal knowledge)

f. Undocumented immigrants

“One participant of questionnaire test group in Chinese arrived in Canada in 2001. She is now undocumented. Since six years, she is unemployed after a serious road accident. She has only very limited health coverage offered by car insurance related to the accident. She has no health coverage for her daily primary care need.”

(CR Groupe de discussion en chinois sur questionnaire)

However, the reason why she is always refused by the Canadian government for a regular migratory status is unknown.

3.3.2 Pattern of activities and organizations of Chinese migrants in Montreal

a. Some Chinese community service centre works with Chinese migrants' family. On the contrary, it has very limited implication in young Chinese migrants population and Chinese students.

“Alors que Ke a posé une question pour savoir ce que l'organisme a fait pour les jeunes chinois à Montréal, la réponse de Mme Xixi Li n'est pas satisfaisante. Elle a répondu que la plupart de leurs bénévoles étaient des étudiants chinois. On a l'impression que cet organisme ne travaille pas beaucoup avec les jeunes chinois à Montréal. “

(CR Participation à l'assemblée générale du Service à la famille chinoise du Grand Montréal)

This suggests that single social organization of Chinese community do not cover adequately immigrants of certain profile(s) identified in the profile list of Chinese MSAM. When recruiting participants through a social-organizational pathway, partnerships need to be established with different organizations covering immigrants with different MSAM profiles.

b. Chinese hospital in Montreal, as one of main healthcare centers of Chines community, is dominated by Cantonese-speaking facility users.

“Cela n'est pas un « vrai » hôpital mais plutôt une maison de retraite. Les gens y parlent principalement cantonais. “

(CR sortie quartier chinois 10mai2016)

Cantonese-speaking community and Mandarin-speaking community are culturally connected but social-organizationally in some degree separated for several reasons. This separation is also observed in Chinese immigration population in Montreal and need to be considered in heterogeneity

c. The “qualitative” distribution of Chinese immigrants in Montreal

The information on “qualitative” distribution of the Chinese immigrants in Montreal would be very useful for quasi-venue-based approach sampling in regard of assuring the sample include

immigrants from different layers.

“We can distinguish two main activity areas of Chinese community in Montreal: Chinese quarter in Montreal and the part of boulevard Ste-Catherine between rue Guy and Atwater. There is an obvious difference in composition of Chinese immigrants in the two areas.”

(CR sortie quartier chinois 10mai2016)

Chinese immigrants with young children are likely to live in arrondissement Saint-Laurent, where they can easily find Chinese school for their children born in Canada being able to speak Chinese, and where a lot of maison détaché and uni-famille (two housing types) are available and good for new immigrants' families. In arrondissement Ville-Marie, the first Chinese migrants arrived in the 19 century and speak mostly Cantonese. In arrondissements Villeray-Saint-Michel-Parc-Extension, Cote-des-neiges, la Salle, housing are relatively cheap, therefore the concentration of immigrants of all origins is high. (Qualitative draft map made during Chinese interviewers' discussion. See Annexe 1)

3.4 Understanding the distribution of Chinese MSAM in Montreal

(See annexes 3, 4)

Statistics Canada's data of 2011 census have been used for visualizing the distribution of immigrants. Two groups of attributes are used: Number of residents with and without Canadian citizenship by arrondissements of Montreal; Number of residents of which mother languages are Chinese or Cantonese(Statistics Canada classify Mandarin and all other Chinese dialects that are not Cantonese as Chinese; Statistics Canada, 2011). Shapefiles and related geographic information for GIS of Montreal and of its arrondissements are retrieved on the site of Ville de Montreal(Ville de Montreal, 2016).

183 immigrants' activity and organization places of ethnic communities included in the study are geo-coded. 39 of them are related to the Chinese community. The GIS committee in the project looks forward to explor more information through those data.

2.4.1 Extended use of GIS

GIS for organizing field work

For attaining the best working efficiency, interviewers should be sent to right places where there will be a relatively strong presence of MSAM. One of the concentration in field work preparation is to identify those places. Interviewers in the project are recruited from different communities, including Chinese, Mexican, Haitian, Iranian, south Asian, African, Arabian-speaking communities

and other communities. Their knowledge of their own community in Montreal is one of the selection criteria. During interviews' training, a workshop has been organized for identifying places that they think where would be with a high presence of MSAM of their own community. They were writing those place on papers. The first GIS task was to Geotag those places. The project coordinator will then use the Geo-tagged information of organizing the fieldwork by choosing days and places and specific interviewers. Field work information such as how many times the project has deployed interviews in each place; how many eligible respondents have been recruited in each place will be synchronized in forms of attributes in GIS. This helps to attain a perfect surveillance and organization of filed work. Repeated deployment can be avoided. Location information will be sent to interviewers with geographic coordinates before each deployment. By manipulating all these geographic information, the project team can control the geographic pattern of sampling. Which allows to say that even it is a non-probabilistic sampling, the samples that have been taken are in some level quasi-representative.

GIS for collecting data and interpreting study result

The questionnaire has been programmed into tablet computers, and in the end of it, the geographic coordinate of the place where it has been done will be recorded. The home address of respondent is also collected in the questionnaire. However, for confidentiality and research ethical reasons, respondents' address is only collected in the precision of *Arrondissement* of Montreal.

This two information allows us to do mapping for visualizing the geographic distribution all other information collected in the questionnaire.

Geographic tools used and logistic preparation

Google My Maps is an online service allowing people to do basic GIS operations with an user-sfriendly interface similar to Google Maps. The geographic information collected in it can be exported as KML format file which can be read by more specialized GIS programs. All the places identified in a workshop during interviewers' training are inputted by using Google My Maps. Interviewers will also visualize assigned locations for their field work by using it.

QGIS is an open source GIS program. It is used for mapping and analyzing all geographic information in the project. A guide to the use of Google My Maps were produced for generalizing its use in the research team. Two QGIS training with 18 hours of lecture were helpful. In total 4 operators work in GIS.

3.5 Preliminary respondent recruitment strategy for Chinese MSAM

Key features of the preliminary strategy include: Considering the dimensions of heterogeneity of the target population and addressing the dimensions in sampling; Adopting an operational multiple pathways recruitment plan; Reducing barriers for recruitment and adding incentives for

participants; Figure 7 shows the mechanism of the strategy.

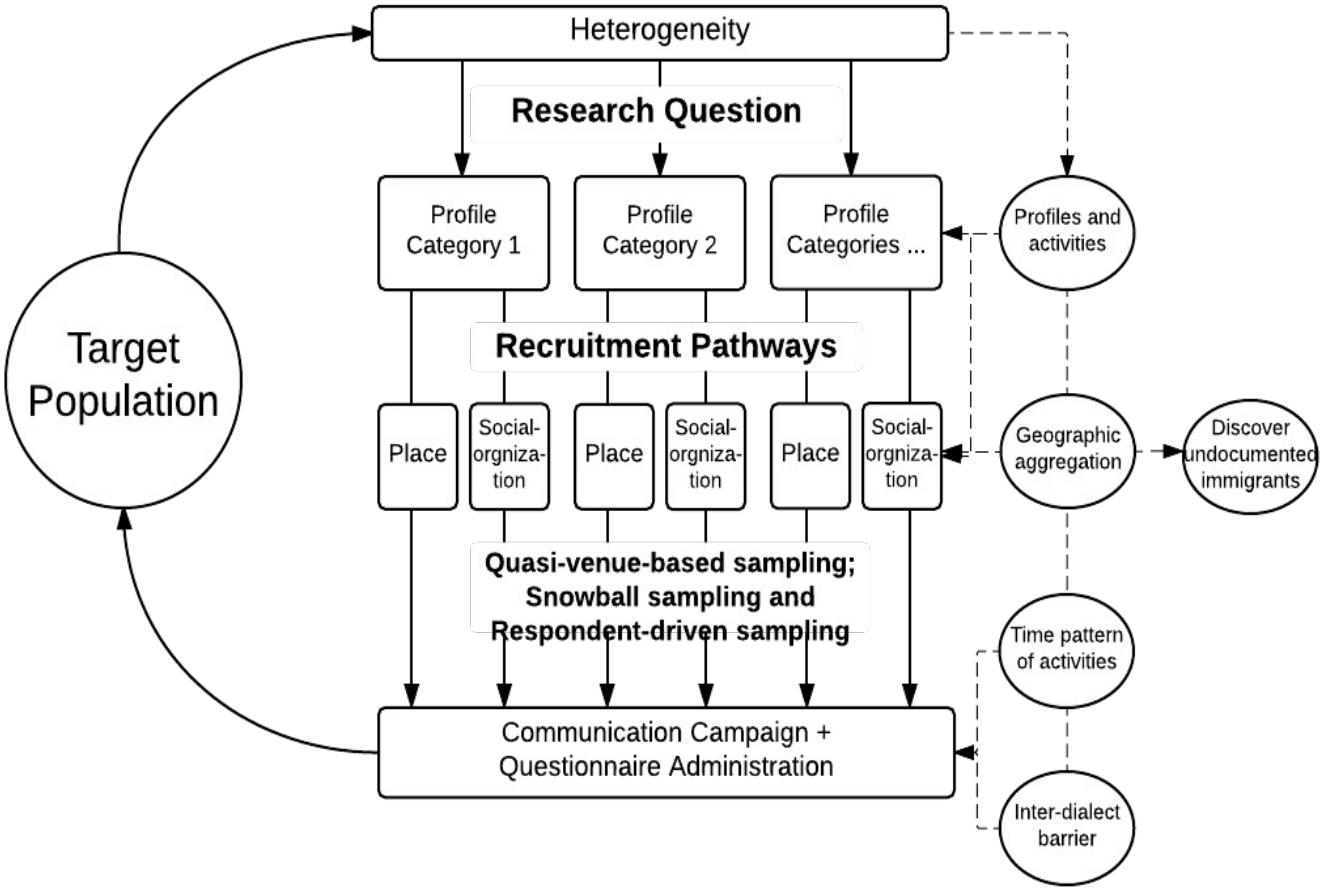

Figure 7. The mechanism of the preliminary MSAM recruitment strategy

3.5.1 Dimensions of heterogeneity of the target population

Heterogeneity is the most common characteristic of populations for Public Health research. It does not have one fixed definition or single fixed form. Even in the same population, distinctive forms of heterogeneity can be revealed according to different research questions.

To be more specific, information in the result part of this paper suggests several aspects of heterogeneity of the population of Chinese MSAM. Once again, research questions here are: How immigrants become uninsured and what are their profiles? How and where to reach uninsured immigrants?

Immigrants' profile and their activities				
University students	Graduated university students changing migratory status	University students' parents	Educational immigrants	Foreign workers' family members

Immigrants' culture	
Mandarin-speaking Chinese immigrants	Cantonese-speaking Chinese immigrants
Some inter-dialect barrier in China is also observed in Chinese community in Montreal	

Immigrants' geographic aggregation			
Chinese quarter in arrondissement Ville-Marie	Road Ste-Catherine between rue Guy and Atwater	Arrondissement Saint-Laurent	Arrondissments Cote-des-neiges, la Salle
Cantonese-speaking	University quarter with young immigrants	Susceptible with more educational immigrants	General immigrants

Immigrants' activities' time pattern	
University students are difficult to reach in summer because of vacation	Elder Chinese immigrants go more often to travel agencies in summer for traveling inside Canada

Irregular immigrants	
Immigrants with residence permit	Undocumented immigrants

3.5.2 An operational multiple pathways recruitment plan

We distinguish two concepts in the participant recruitment strategy in our project: recruitment method and recruitment pathway. Principle recruitment methods are quasi-venue-based sampling and Social-organizational sampling. Recruitment pathways mean places in which and structures through which recruitment methods will be applied.

Quasi-venue-based sampling can be understood as sampling by places. Interviewers will be sent to the field and contact with people and take convenience samples. This approach is similar to venue-based sampling and time-location sampling methods identified in the protocol of the project. The premise of using them is the existing prevalence information on the target population, as they use probabilistic sampling approach. However, this information is not available for our target population- MSAM. Therefore, the two methods cannot be actually used in our project(Aho et al. 2016). This is the reason why our project chose to use a compromise way. Sampling will be conducted in places with strong presence of migrants that are identified by project interviewers from different ethnic communities. More samples will be taken in arrondissements with higher migrant density according to information extracted from Statistics Canada 2011 census.

Social-organizational sampling can be understood as sampling using the link between people,

through social structures and social networks. Respondent-driven sampling and Snowball sampling are reference methods. Social structures include community centerss and services (travel agencies, Immigration consulting agencies, employment agency, schools, International student office of universities, churches etc.). Social networks of people include those of university students, educational immigrants, elder immigrants. People in each group shear a common topic or a common interest around which the communicates with each others.

Finally, recruitment pathway means the concrete sampling route for applying the two sampling methods. For example, one pathway to recruit university students can be working with student unions. Quasi-venue-based sampling approach can be applied by sending interviewers to student unions' activity places in main universities in Montreal. Social-organizational sampling can be applied by contacting key person of student unions for spreading communication materials and messages; or by starting the snowball with the first recruited uninsured students.

Following charts show how the two sampling methods work with multiple recruitment pathways in the preliminary recruitment plan of our project.

Immigrants' profile	
Places for Quasi-venue-based sampling	Structures of Social-organizational sampling

University students	
Places	Social-organizations
Interviewers take convenience samples in the road Ste-Catherine between rue Guy and Atwater (strong presence of Chinese university students)	Work with student unions, BEI (Bureau des étudiants internationaux-international student office) in main universities in Montreal

Graduated university students changing migratory status	
Places	Social-organizations
Employment agencies in Chinese quarter; Immigration consulting agencies;	Snowball starts with university students; Employment agencies and immigration agencies; Chinese community online forums and other cyber social networks

University students' parents	
Places	Social-organizations
Service for Chinese Families in Greater Montreal; Pharmacie of Chinese Medicine	Same as left; Snowball starts with Mme ZHENG, University students mother, participant of Chinese questionnaire test group

Educational immigrants	
Places	Social-organizations
Chinese Kindergartens in Montreal; Service for Chinese Families in Greater Montreal; Chinese youth language schools, music schools; Arrondissement Saint-Laurent	Same as left; Snowball starts with Mme ZHANG, newly arrived immigrants for schooling her four-year-old daughter in Montreal; Wechat(Chinese social network mobile application) group of Chinese mothers in Montreal

Foreign worker's family members	
Places	Social-organizations
Clinics of Chinese communities; Parks in Montreal where Chinese elderlies do morning exercises; Chinese grocery stores; Arrondissements Cote-des-neiges, la Salle	Clinics of Chinese communities; Chinese online forums

Undocumented	
Places	Social-organizations
Service for Chinese Families in Greater Montreal; Chinese churches; Chinese grocery stores; Arrondissements Cote-des-neiges, la Salle	Service for Chinese Families in Greater Montreal; Chinese churches

3.5.3 Reducing barriers for recruitment and adding incentives for participants;

The project allocates 20 Canadian dollars as compensation for the time that each participant used for responding the questionnaire and orientate participants to organizations taking charge of uninsured immigrants' health needs. However, it is not enough to remove barriers to their participation and more incentives for participation are needed. The research team identified other barriers including Lack of awareness of the issue related to the research question; lack of willingness of giving sensible personal information; lack of trust on interviewers and research team. The communication committee in the project is conducting a multidimensional communication campaign. The basic assumption for the campaign is that: if an uninsured immigrant received repeatedly the information of the project in its daily life, it will be more likely to be motivated to participate the project. It can contact project team actively with the telephone number on communication materials. Or it will be more cooperative when project interviewers meet it in the field.

The communication campaign includes two types of actions: Social-organizational communication and Venue-based communication. In the first type, formal communication pathways are used, such as mass communication with community newspapers, radios, social networks. Moreover, several consulates of immigrants' original countries are also contacted. Through this way, the committee wish to create an atmosphere in immigrant's community for mobilizing more community resources and for increasing their trust toward the research project. In the second type of actions, the committee send project interviewers in identified immigrants' activity and organization places. Cultural validated flyers, visit cards are placed and posted in grocery stores, community centres etc. The way of formulating information on communication materials is also important. For instance, the information on confidentiality of the survey is stressed for reducing barriers to participation.

4. Conclusion

MSAM are not limited in a single migratory status layer, social economic layer, demographic layer, and they include undocumented people. No registry is available for this population. The prevalence is unknown and their geographic aggregation pattern has not been studied. This paper proposed a mixed plan to do a non-probabilistic sampling. In the development process of the strategy, first, we asked what are the aspects of heterogeneity of the target population regarding the research question: How and where to reach MSAM. Second, data collected in the project preparation stage on Chinese community were used to answer the question on the heterogeneity. Third, a preliminary recruiting strategy integrating several sampling methods and recruitment pathways were with an operational plan.

The advantage of the strategy is considering target population's heterogeneity. Moreover, with its multiple recruitment pathways, communication campaign, and cultural adaptation, it theoretically allows attaining a relatively good response rate.

5. Discussions

5.1 Limitation of the preliminary strategy

The current categorization of target population's profiles is a result of the qualitative analysis of data collected in the first stage of participant recruitment strategy development. The data is not exhaustive and need to be enriched with more diverse sources and more abundant. In the second

stage of the strategy development, qualitative data from field works will be added. With new data, new categories would be added, some existing categories would be merged with others, remained categories will be further justified with new evidence. As a consequence, the recruitment strategy will experience an ongoing amelioration process, and will be improved comparing to the preliminary strategy presented in this paper. More literature reviews are needed for understanding historical and recent trends of the migratory trajectory of the Chinese community. Concerning sampling methods, more efforts are needed on how to use non-probabilistic sampling methods in a rigorous way.

5.2 Diffusion and interpretation of study result.

Not totally pertinent regarding the theme of this paper, figure 8 displays a possibility of our study being harmful to target population because of certain stakeholder is acknowledged of the study result. Even though this illustration is hypothetical, the issue will need to be considered.

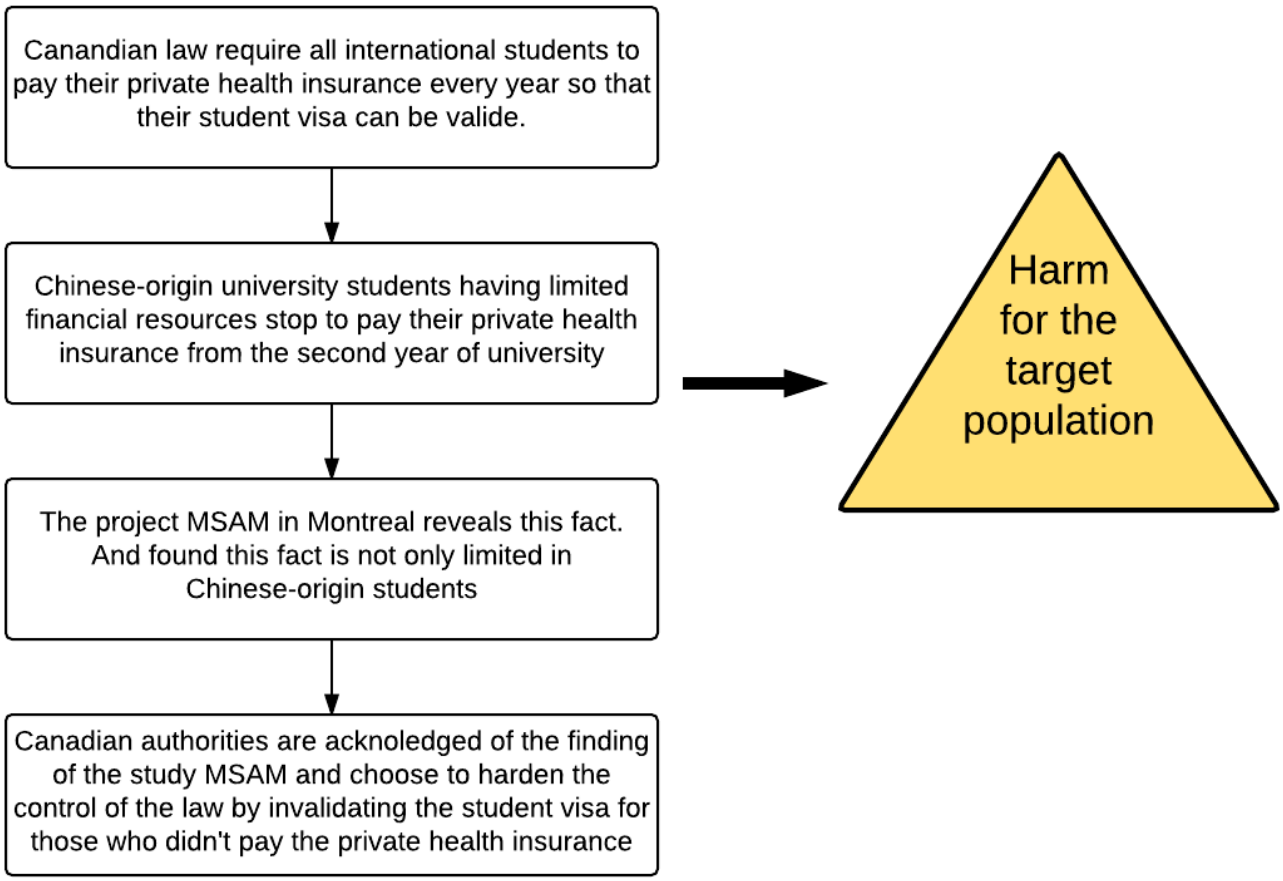

Figure 8. A hypothetical ethical issue in result diffusion of the study MSAM in Montreal The case of Chinese-origin uninsured university students

The issue of interpreting study result also merits careful considerations. Figure 9 gives a hypothesis of how a Hispanic-Paradox-like study result can be used for advocating, and how it can be harmful to target population if manipulated.

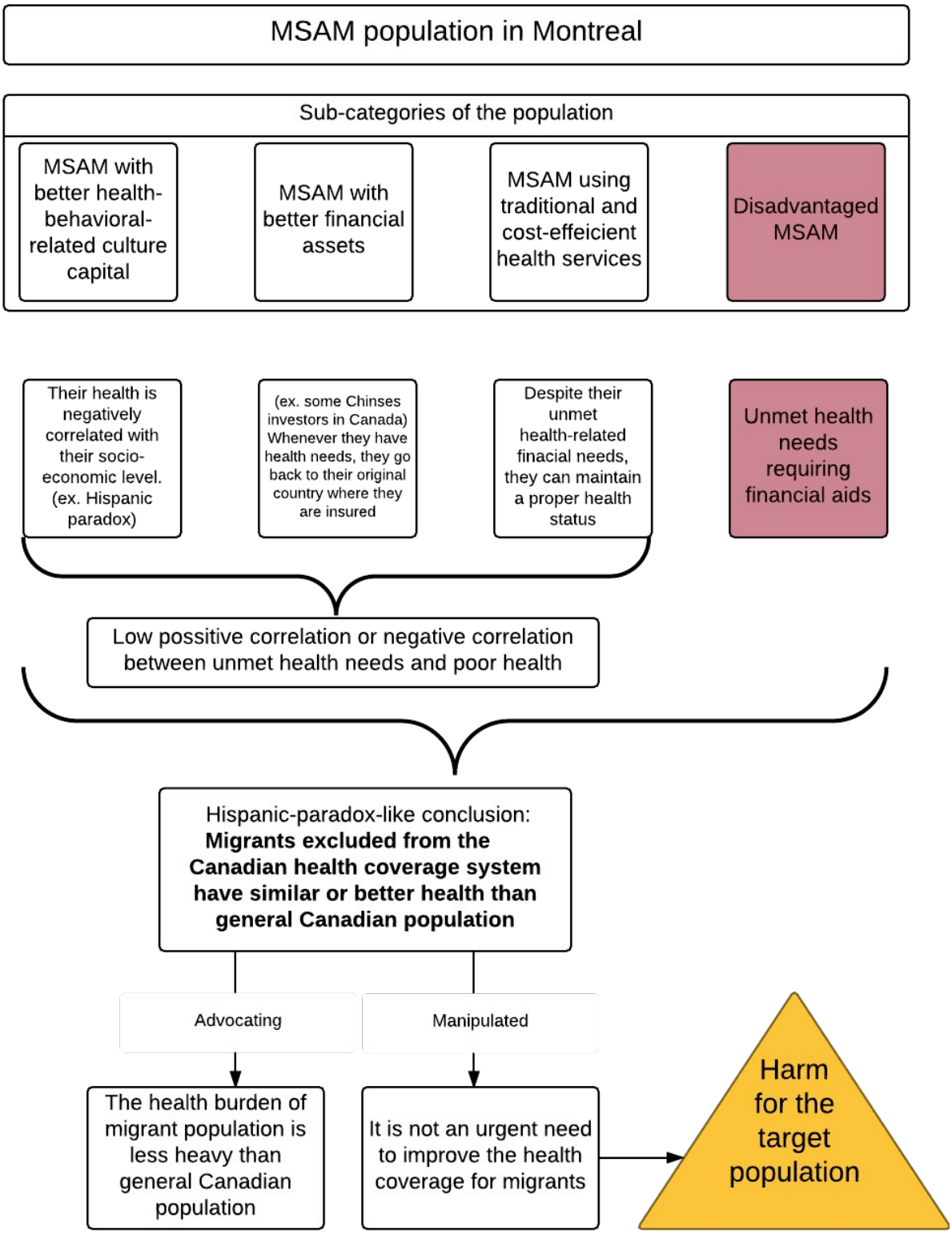

Figure 9. A hypothetical issues in interpretation of result of the study MSAM in Montreal

The case of Hispanic-paradox-like conclusion

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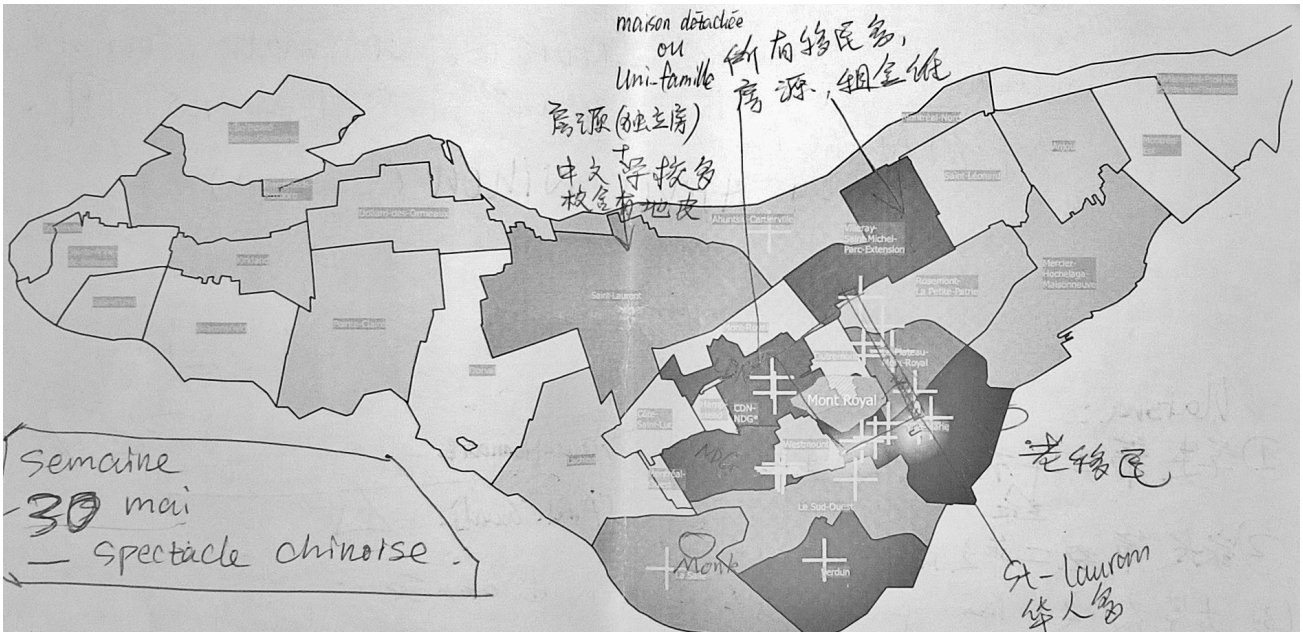
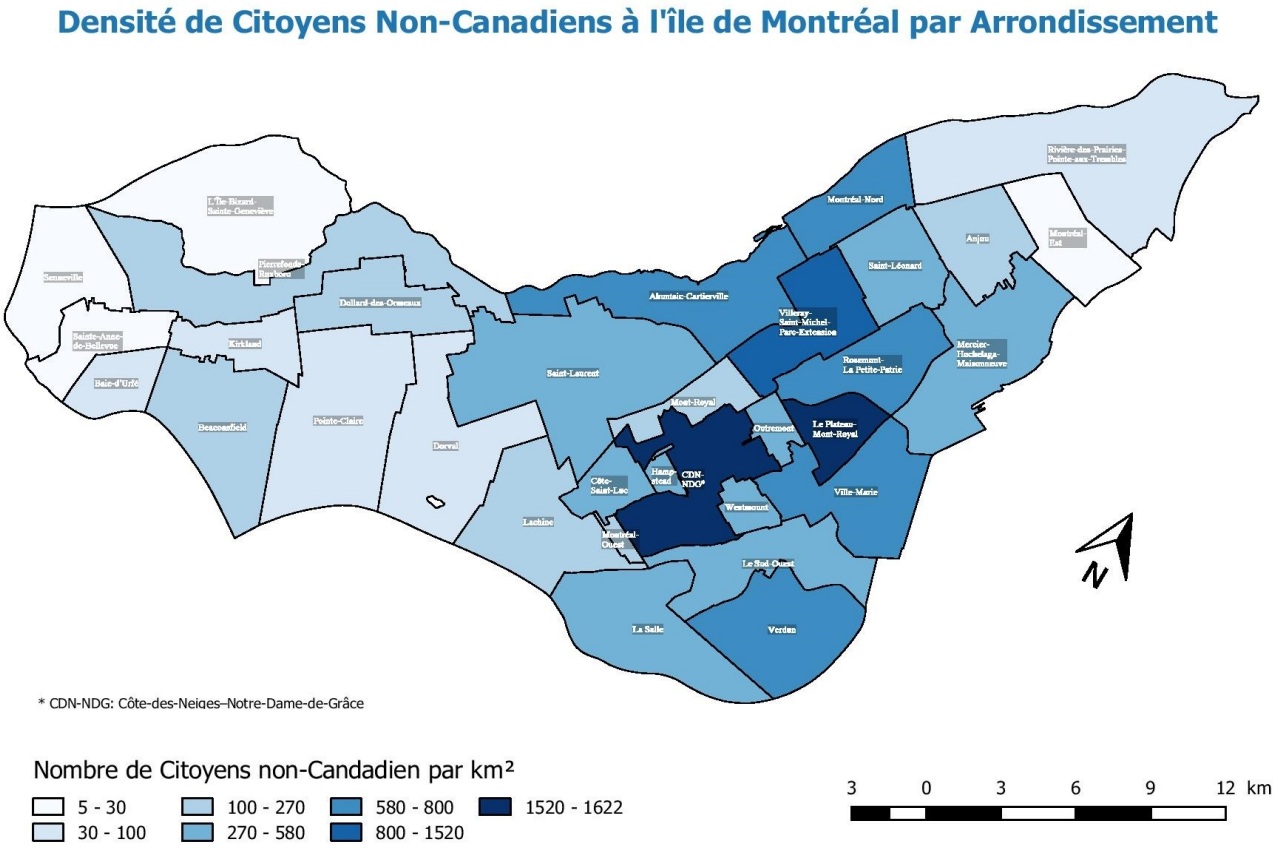
List of Annexes

1. Qualitative draft map made during Chinese interviewers' discussion
2. Mapping of density of non-Canadian citizens by Arrondissements in Montréal
3. Mapping of density of Chinese-speaking and Cantonese-speaking citizens
4. Questionnaire used in the project “How to improve health and access to healthcare for uninsured migrants in Montreal”.

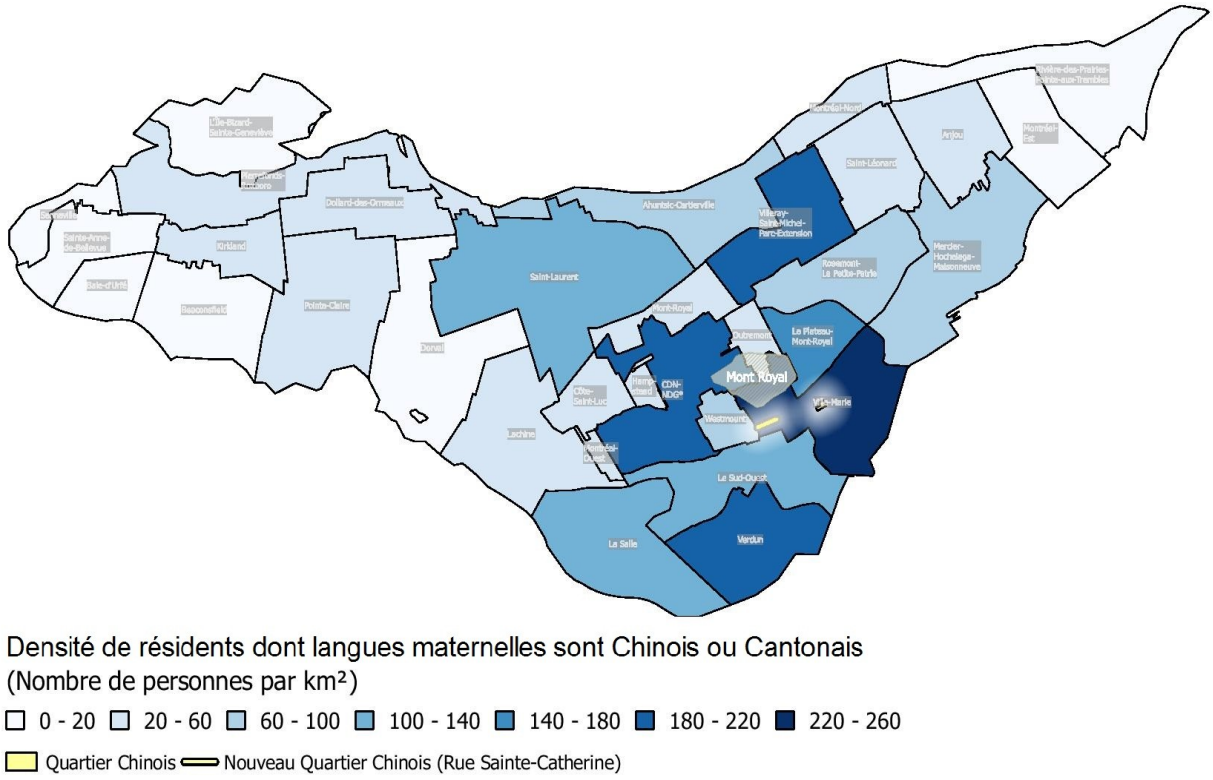
Annexe 1. Qualitative draft map made during Chinese interviewers' discussion



Annexe 2. Mapping of density of non-Canadian citizens by Arrondissements in Montréal



Annexe 3. Mapping of density of Chinese-speaking and Cantonese-speaking citizens by Arrondissements in Montréal



Annexe 4. Questionnaire used in the project “How to improve health and access to healthcare for uninsured migrants in mitgrants.

ENQUÊTEUR

Identification de l’enquêteur No.

Date de l’entrevue:

2	0						

Année Mois Jour

Heure de début:

Heure(24) Min

Heure de fin:

Heure(24) Min

PARTICIPANT

Numéro de dossier MdM
Pour les participants recrutés à la clinique,
Possibilité d’entrer des chiffres et des lettres
Ce champ sera possiblement vide dans beaucoup de cas

Langue du questionnaire: **1** □ **Français** 2 □ Anglais 3 □ Créole haitien 4 □ Espagnol
5 □ Arabe 6 □ Mandarin 97 □ Autre, spécifiez _____

Qui a informé le participant sur le projet recherche?

1 Enquêteur
2 Ami/famille/ quelqu’un de la commuanuté qui a passé le questionnaire
3 Ami/famille/ quelqu’un de la commuanuté qui a entendu parlé du projet
4 Personnel d’un organisme communautaire
5 La personne a entendu parler du projet (radio, journal, flyer du projet)
97 Autre , spécifiez_____

Qui a fait la traduction lors de la passation du questionnaire?

1 Enquêteur
2 Bénévole
3 Interprète
4 Membre de la famille
5 Membre de la communauté

97 Autre, spécifiez_____

**Les deux questions précédents doivent apparaître dans le questionnaire, je n'arrive pas à enlever le gris

DONNÉES SOCIO-DÉMOGRAPHIQUES

Je vais d'abord vous poser quelques questions générales sur vous et vos enfants.

1. Etes-vous :	1 un homme 2 une femme 3 transexuel ou transgenre 97 Autre, spécifiez : _____
2. Quel est votre âge? 0-99	☐☐☐ ans
3. Quel est votre état matrimonial?	1 marié(e) 2 union libre/conjoint de fait 3 veuf/ veuve 4 séparé(e) 5 divorcé(e) 6 célibataire
4. Quel est le plus haut niveau d'études que vous avez terminé?	1 école primaire 2 école secondaire 3 diplôme post-secondaire non-universitaire (ex. Diplôme d'études professionnelles, cégep, métier) 4 diplôme universitaire de 1er cycle 5 diplôme universitaire de 2e cycle ou 3e cycle (ex: maîtrise ou doctorat) 6 aucun
5. Quel est votre pays natal? Faire apparaître une liste de pays lorsque l'enquêteur tape les premières lettres, sinon laissez en réponse ouverte	_____
6. Depuis combien de temps vivez-vous au Québec? Inscrire 0-11 mois (si moins d'un an) ou 1-60 années ***offrir une réponse en mois ou années, si ce n'est pas possible, laissez en réponse ouverte	☐☐☐ Mois/Années

7. Dans quel quartier habitez-vous? Faire apparaître une liste des quartiers suivants lorsque l'enquêteur tape les premières lettres, sinon laissez le choix de réponse complet	1 Anjou 2 Aunthic-Cartierville 3 Baie D'Urfé 4 Beaconsfield 5 Côte-des-Neiges/Notre-Dame-de-Grâce 6 Côte-Saint-Luc 7 Dollard-des-Ormeaux 8 Dorval 9 Hampstead 10 Lachine 11 Lasalle 12 L'île Bizzard/Sainte-Geneviève 13 L'île de Dorval 14 Mercier/Hochelaga-Maisonneuve 15 Montréal Est 16 Montréal-Nord 17 Montréal-Ouest 18 Mont-Royal 19 Pierrefonds/Roxboro 20 Plateau Mont-Royal 21 Pointe-Claire 22 Rivière-des-Prairies/Pointe aux Trembles 23 Rosemont/La Petite Patrie 24 Sainte-Anne-de-Bellevue 25 Saint-Laurent 26 Saint-Léonard 27 Senneville 28 Sud-Ouest 29 Verdun 30 Ville-Marie 31 Villeray/Saint-Michel/Parc extension 32 Westmount 33 Habite à Laval ou sur la rive Nord 34 Habite à Longueil ou sur la rive Sud 97 Autre, spécifiez:- _____ 98 Ne sait pas

8. Depuis combien de temps environ êtes-vous sans assurance médicale? Inscrire 0-11 mois (si moins d'un an) ou 1-60 années ***si possible de sélectionner une réponse en mois ou années, sinon, la réponse sera ouverte	☐☐☐ Mois/Années 98 Ne sait pas
9. Avez-vous une assurance de santé privée ? Si non, passez à la question 11	1 Oui, au travail de mon conjoint 2 Oui, à mon travail 3 Non Passez à 11 98 Ne sait pas
10. Quels services de santé sont couverts par cette assurance de santé privée? Cochez toutes les réponses qui s'appliquent	1 Médicaments 2 Dentiste 3 Optométrie/lunettes 4 Physiothérapie et autres professionnels 97 Autre, spécifiez: _____ 98 Ne sait pas

11.

	Très bon	Bon	Faible	Nul
Quel est votre niveau de français?				
Parlé	□	□	□	□
Lu	□	□	□	□
Compris	□	□	□	□
Quel est votre niveau d'anglais?				
Parlé	□	□	□	□
Lu	□	□	□	□
Compris	□	□	□	□

Enfants

12. Combien d'enfants de moins de 18 ans avez-vous? 0-25	☐☐☐ (si 0, passez à 17)

13. Combien de vos enfants de moins de 18 ans vivent avec vous? 0-25	☐☐☐ (si 0, passez à 17)
14. Est-ce que votre/vos enfant(s) né(s) au Québec a/ont la carte d'assurance maladie (carte RAMQ, soleil)?	0 Ne s'applique pas (enfants nés à l'extérieur du Québec) 1 Tous mes enfants nés au Québec ont la carte RAMQ 2 Seulement certains de mes enfants nés au Québec ont la carte RAMQ 3 Aucun de mes enfants nés au Québec n'a la carte RAMQ 98 Ne sait pas
15. Est-ce que votre/vos enfant(s) de plus de 6 ans va/vont à l'école?	0 Ne s'applique pas (enfants ont tous moins de 6 ans) 1 Tous mes enfants de plus de 6 ans vont à l'école 2 Seulement certains de mes enfants de plus de 6 ans vont à l'école 3 Aucun de mes enfants de plus de 6 ans ne va à l'école 98 Ne sait pas
16. Est-ce que vos enfants de moins de 6 ans fréquentent un milieu de garde/ garderie?	0 Ne s'applique pas (enfants ont tous plus de 6 ans) 1 Oui, plusieurs jours/ soirs par semaine 2 Oui, ocasionnellement 3 Non, aucun de mes enfants ne va à la garderie 98 Ne sait pas

ÉTAT DE SANTÉ

Les prochaines questions constituent l'aspect le plus important de notre recherche. Elles portent sur votre état de santé et sur des problèmes de santéque vous avez eu. Vos réponses à ces questions demeurent confidentielles et anonymes.

PERCEPTION DE L'ÉTAT DE SANTÉ

17. En général, diriez-vous que votre santé est :	1 mauvaise 2 passable 3 bonne 4 très bonne 5 excellente

MALADIES CHRONIQUES

J'aimerais vous poser quelques questions sur des problèmes de santé physique ou mentale qui ont été diagnostiqués par un professionnel de la santé.

18. Est-ce qu'un professionnel de la santé vous a déjà dit que vous souffrez d'un problème de santé?

1 Oui Passez à 18.1
2 Non Passez à 19
98 Ne sait pas Passez à 18.1

18.1 Lequel? Cochez toutes les réponses qui s'appliquent, faire apparaître tout sur la même page

1 diabète, c'est-à-dire, un niveau élevé de sucre dans le sang (sauf pendant une grossesse)
2 hypertension artérielle, c'est-à-dire une tension élevée ou de la haute pression (sauf pendant une grossesse)
3 d'un cancer ou d'une tumeur maligne, excluant les cancers bénins de la peau
4 d'une maladie pulmonaire chronique comme la bronchite chronique, l'emphysème ou l'asthme
5 d'une maladie chronique du système digestif c'est-à-dire la maladie de Crohn, une colite ulcéreuse ou une rectocolite hémorragique
6 d'une attaque cardiaque, maladie coronarienne, d'angine de poitrine ou d'insuffisance cardiaque, ou encore d'autres problèmes cardiaques
7 d'une embolie cérébrale, d'un accident vasculaire cérébral (AVC) ou d'une thrombose
8 d'arthrite, de rhumatismes ou d'arthrose
9 de tuberculose
10 d'hépatite B
11 d'hépatite C
12 de VIH /SIDA
13 d'un trouble de l'humeur comme la maladie affective bipolaire ou la dépression chronique
14 d'un trouble anxieux, comme les phobies, le trouble d'anxiété généralisé, l'agoraphobie ou le syndrôme de stress post-traumatique
97 Autre, spéficifez:_____

DÉTRESSE PSYCHOLOGIQUE

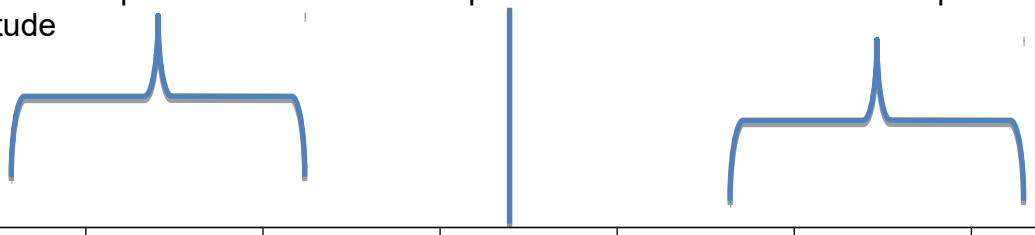
19. KESSLER 6	
19.1 Les questions suivantes portent sur la façon dont vous vous êtes senti (e) au cours du dernier mois.	
Combien de fois avez vous eu le sentiment d'être nerveux/nerveuse- diriez-vous tout le temps, la plupart du temps, quelquefois, rarement ou jamais?	1 tout le temps 2 la plupart du temps 3 quelquefois 4 rarement 5 jamais 98 ne sait pas 99 ne souhaite pas répondre
Combien de fois avez vous eu le sentiment d'être désespéré (e)? - diriez-vous tout le temps, la plupart du temps, quelquefois, rarement ou jamais?	1 tout le temps 2 la plupart du temps 3 quelquefois 4 rarement 5 jamais 98 ne sait pas 99 ne souhaite pas répondre
Combien de fois avez vous eu le sentiment d'être agité (e) ou impatient (e)? - diriez-vous tout le temps, la plupart du temps, quelquefois, rarement ou jamais?	1 tout le temps 2 la plupart du temps 3 quelquefois 4 rarement 5 jamais 98 ne sait pas 99 ne souhaite pas répondre
Combien de fois avez vous eu le sentiment d'être tellement déprimé (e) que rien ne pouvait vous remonter le moral? - diriez-vous tout le temps, la plupart du temps, quelquefois, rarement ou jamais?	1 tout le temps 2 la plupart du temps 3 quelquefois 4 rarement 5 jamais 98 ne sait pas 99 ne souhaite pas répondre
Combien de fois avez vous eu le sentiment que tout vous demandait un effort?- diriez-vous tout le temps, la plupart du temps, quelquefois, rarement ou jamais?	1 tout le temps 2 la plupart du temps 3 quelquefois 4 rarement 5 jamais 98 ne sait pas 99 ne souhaite pas répondre
Combien de fois avez vous eu le sentiment de n'être bon à rien? -diriez-vous tout le temps, la plupart du temps, quelquefois, rarement ou jamais?	1 tout le temps 2 la plupart du temps 3 quelquefois 4 rarement

	5 jamais 98 ne sait pas 99 ne souhaite pas répondre

19.2 Les questions précédentes portaient sur des sentiments que vous avec pu éprouver au cours du dernier mois, Dans l'ensemble, au cours du dernier mois, avez-vous éprouvé ces sentiments plus souvent, à peu près aussi souvent ou moins souvent qu'à l'habitude?

Il serait important ici d'avoir un certain visual...celui là ou ce qui est possible de faire!

Plus souvent que d'habitude — Aussi souvent que d'habitude — Moins souvent que d'habitude



Beaucoup plus souvent	Plûtot plus souvent	Un peu plus souvent		Un peu moins souvent	Plutôt moins souvent	Beaucoup moins souvent
1	**2**	**3**	**4**	**5**	**6**	**7**

Les questions suivantes portent sur les conséquences que ces sentiments ont pu avoir sur vous au cours du dernier mois.

19.3 Pendant combien de jours avez-vous été totalement incapable de travailler ou d'accomplir vos activités habituelles en raison de ces sentiments? 0-31	_____ (Nombre de jours)
19.4 Pendant combien de jours n'avez-vous pu faire que la moitié, voire moins, des choses que vous auriez normalement été capable de faire si vous n'aviez pas éprouvé ces sentiments? 0-31 Sans compter les jours indiqués dans la réponse précédente	_____ (Nombre de jours)
19.5 Combien de fois avez-vous consulté un médecin ou un autre professionnel de santé à propos de ces sentiments? 0-15	_____ (Nombre de fois)
19.6 Au cours du dernier mois, est-il arrivé que ces sentiments soient principalement provoqués par des problèmes de santé physique?	1 tout le temps 2 la plupart du temps 3 quelquefois 4 rarement 5 jamais 98 ne sait pas 99 ne souhaite pas répondre

ATTITUDES, PRATIQUES ET CONNAISSANCES DE SANTÉ

PRATIQUES DE SANTÉ

20. Concernant tous les problèmes de santé étant survenus dans *la dernière année ou depuis que vous êtes sans assurance médicale*: dans *la dernière année : si la personne sans assurance médicale depuis plus d'un an* *depuis que vous êtes sans assurance médicale : si la personne sans assurance médicale depuis moins d'un an (Q8), l'un ou l'autre doit apparaître selon le cas*	
Décrivez-moi les problèmes que vous avez eu… Cochez toutes les réponses qui s'appliquent Si la personne vous dit qu'elle n'a pas eu de problème de santé, demandez-lui si elle n'a pas eu un problème de santé ponctuel ou une rechute de l'une des maladies mentionnées dans la section sur la santé	0 Je n'ai pas eu de problème de santé Passez à 23 1 Santé sexuelle et reproductive 2 Problème ponctuel de santé (grippe, bronchite, pneumonie,etc.) 3 Rechute/complication d'une maladie chronique comme le diabète, l'hypertension artérielle 4 Problème de santé mentale/ consommation 5 Problème dentaire 6 Problème visuel 7 Problème musculo-squelettique (douleur au bras, au cou, au dos) 97Autre, spécifiez _____
Toutes les questions qui suivent concernent tous les problèmes de santé que vous avez eu dans *la dernière année ou depuis que vous êtes sans assurance médicale*: dans *la dernière année : si la personne sans assurance médicale depuis plus d'un an* *depuis que vous êtes sans assurance médicale : si la personne sans assurance médicale depuis moins d'un an (Q8), l'un ou l'autre doit apparaître selon le cas*	
21. Combien de jours avez-vous manqué le travail? 0-365	☐☐☐ 0 ne s'applique pas (la personne ne travaillait pas) 98 Ne sait pas
22. Combien de jours êtes-vous resté au lit? 0-365	☐☐☐ 98 Ne sait pas

23. Avez-vous consulté un professionnel de la santé?	1 Oui 2 Non

CONNAISSANCES SUR LES SERVICES DE SANTÉ

24. Savez-vous où consulter un professionnel de la santé à faible coût ou gratuitement?	1 Oui 2 Non	25. À quels endroits? Réponse ouverte Textuel: 1. 2. 3. 4._____ 5._____ 6._____ 7._____ 8._____ 9._____ 10._____ _

ACCÈS AUX SOINS

Les questions suivantes constituent également une partie importante de notre recherche. Nous souhaitons comprendre quels sont les besoins de santé, les services utilisés et les frais facturés pour ces services.

BESOINS DE SANTÉ NON-COMBLÉS

26. Dans *la dernière année ou depuis que vous êtes sans assurance médicale,* avez-vous ressenti le besoin d'obtenir des soins de santé sans les recevoir ? dans *la dernière année : si la personne sans assurance médicale depuis plus d'un an* *depuis que vous êtes sans assurance médicale : si la personne sans assurance médicale depuis moins d'un*	1 Oui 2 Non Passez à 28 99 Pas de réponse

an (Q8), l'un ou l'autre doit apparaître selon le cas	
27. Pour quelles raisons n'avez-vous pas obtenu les soins de santé? Cochez toutes les réponses qui s'appliquent	1 les services ne sont pas disponibles où je vis 2 les services n'étaient pas disponibles au moment où j'en ai eu besoin 3 l'attente était trop longue 4 je n'avais pas assez d'argent pour payer le service ou les frais exigés 5 je craignais d'avoir une facture trop élevée 6 je suis trop occupé (e) pour me soigner 7 je ne savais pas où aller 8 j'ai eu un problème de transport 9 j'ai eu un problème de langue 10 j'ai des responsabilités familiales ou à la maison qui m'ont empêché d'y aller 11 j'ai peur d'être déporté/ de l'impact sur la demande d'immigration 12 quelqu'un à la clinique/ à l'hôpital a refusé qu'on me donne les soins/de me donner les soins 13 je n'aime pas les médecins/j'ai peur des médecins 14 j'ai décidé de ne pas me faire soigner 15 le problème de santé a été résolu avant que je ne consulte un professionnel de la santé 97 Autre, spécifiez: _____ 99 Pas de réponse
28. **Dans *la dernière année ou depuis que vous êtes sans assurance médicale,*** y a-il des médicaments prescrits	1 Oui 2 Non Passez à 30 99 Pas de réponse

par un médecin que vous n'avez pas pu vous procurer ? dans *la dernière année : si la personne sans assurance médicale depuis plus d'un an* *depuis que vous êtes sans assurance médicale : si la personne sans assurance médicale depuis moins d'un an (Q8), l'un ou l'autre doit apparaître selon le cas*	
29. Pour quelles raisons n'avez-vous pas pu avoir les médicaments? Cochez toutes les réponses qui s'applique	1 je n'avais pas assez d'argent pour payer les frais exigés 2 je craignais d'avoir une facture trop élevée 3 je n'ai pas pu obtenir d'ordonnace médicale-prescription 4 quelqu'un à la pharmacie a refusé de me servir les médicaments 5 je ne savais pas où aller 6 j'ai eu peur d'être déporté/ de l'impact sur la demande d'immigration 7 je n'ai trouvé personne qui pouvait m'envoyer ou récupérer les médicaments de mon pays d'origine 8 j'ai décidé de ne pas prendre les médicaments 9 le problème de santé a été résolu avant que je ne prenne les médicaments 97 Autre, spécifiez: _____ 99 Pas de réponse

SANTÉ REPRODUCTIVE (POUR LES FEMMES)

Nous allons vous demander plusieurs questions personnelles sur la grossesse et l'accouchement et votre utilisation des soins de santé à ce moment. Nous savons que l'absence d'assurance médicale peut limiter l'accès à certains services durant la grossesse ou à l'accouchement.

30. Combien de grossesses avez-vous eu alors que vous étiez sans assurance médicale au Québec? 0-10 Si 0, passez à 41		☐☐☐	
31. Quel âge aviez-vous?	**32. Avez-vous eu**	**33. À quel mois de**	**34**

15-50	**un suivi par un médecin, une infirmière ou une sage-femme?**	**la grossesse avez-vous débuté le suivi avec le médecin, l'infirmière ou la sage-femme?** 1-9	**Combien de visites au médecin, à l'infirmière ou à la sage-femme avez-vous fait pendant la grossesse?**
1er enfant le nombre d'enfant à apparaître dépend de la réponse donnée en 30 Q31 à 40 pour chaque enfant avant de passer au suivant			
	1 Oui 2 Non Passez à 35 99 pas de réponse Passez à 35	6	1 1 fois 2 2 à 5 1 6 à 9 2 10 et plus 98 ne sait pas
2e enfant			
	1 Oui 2 Non Passez à 35 99 pas de réponse Passez à 35		1 1 fois 2 2 à 5 1 6 à 9 2 10 et plus 98 ne sait pas
3e enfant			
	1 Oui 2 Non Passez à 35 99 pas de réponse Passez à 35		1 1 fois 2 2 à 5 1 6 à 9 2 10 et plus 98 ne sait pas

	1er enfant	2e enfant	3e enfant
35. Avez-vous porté l'enfant à terme?	1 Oui 2 Non Passez à 39 99 pas de réponse Passez à 39	1 Oui 2 Non Passez à 39 99 pas de réponse Passez à 39	1 Oui 2 Non Passez à 39 99 pas de répo nse Passez à 39
36. Où avez-vous accouché?	1 à l'hôpital 2 dans une maison de naissance 3 à la maison 97 autre: _____	1 à l'hôpital 2 dans une maison de naissance 3 à la maison 97 autre: _____	1 à l'hôpit al 2 dans une maiso n de naiss ance 3 à la maiso n 97 autre: _____
37. Pour quelles raisons avez-vous choisi d'accoucher (réponse de la question 36 apparaî ici)? Cochez toutes les réponses qui s'appliquent	1 choix personnel 2 conseil de la famille ou partenaire 3 aspect financier 4 peur 97 autre: _____ 99 pas de réponse	1 choix personnel 2 conseil de la famille ou partenaire 3 aspect financier 4 peur 97 autre: _____ 99 pas de réponse	1 choix perso nnel 2 conseil de la famill e ou parte naire 3 aspect financ ier 4 peur 97 autre: _____ ___ 99 pas de répon se

38. Combien vous a-t-on demandé de payer pour les services suivants? 0-200 000 Tous les items doivent apparaître et l 'enquêteur clique sur ceux où il a une réponse du participant	Suivi médical avant l'accouchement: ____________$ Médecin (accouchement) ____________$ Anesthésie locale (Épidurale): ____________$ 1 n'a pas eu d'épidurale Frais hospitaliers: ____________$ Total des frais: ____________$ 98 ne sait pas	Suivi médical avant l'accouchement: ______________$ Médecin (accouchement) ______________$ Anesthésie locale (Épidurale): ______________$ 1 n'a pas eu d'épidurale Frais hospitaliers: ____________$ Total des frais: ____________$ 98 ne sait pas	Suivi médical avant l'accouchement: ______________$ Médecin (accouchement) ______________$ Anesthésie locale (Épidurale): ______________$ 1 n'a pas eu d'épidurale Frais hospitaliers: ______________$ Total des frais: ______________$ 98 ne sait pas

39. Avez-vous fait un avortement?	1 Oui 2 Non Passez à 41 99 pas de réponse Passez à 41	1 Oui 2 Non Passez à 41 99 pas de réponse Passez à 41	1 Oui 2 Non Passez à 41 99 pas de réponse Passez à 41
40. Quelle méthode avez-vous utilisé pour l'avortement?	1 Avortement médical 2 Avortement avec des methodes traditionnelles 97 Autre, spécifiez_____ 99 pas de réponse	1 Avortement médical 2 Avortement avec des methodes traditionnelles 97 Autre, spécifiez_____ 99 pas de réponse	1 Avortement médical 2 Avortement avec des methodes traditionnelles 97 Autre, spécifiez_____ 99 pas de réponse

UTILISATION DES SERVICES DE SANTÉ

La prochaine section porte sur les services de santé que vous avez tenté de consulter.

41. Dans *la dernière année ou depuis que vous êtes sans assurance médicale*, avez-vous tenté d'utiliser les services de santé suivants: dans *la dernière année : si la personne sans assurance médicale depuis plus d'un an* *depuis que vous êtes sans assurance médicale : si la personne sans assurance médicale depuis moins d'un an (Q8), l'un ou l'autre doit apparaître selon* le cas Q41 à 43 pour chaque service		**42. Combien de fois avez-vous utilisé ces services?**	**43. Combien avez-vous a été facturé au total?** 0 à 100 000 pour tous
Info-santé 811	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	Gratuit
Pharmacie	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
Clinique médicale sans rendez-vous (non-CLSC)	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
Hôpital/ urgence	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus	_____ __$

		5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	98 ne sait pas
Centre local de services communautaires (CLSC)	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
PRAIDA	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
Ostéopathie, chiropratie, naturopatie, etc.	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
Clinique dentaire	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
Clinique d'optométrie	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas

Clinique de réadaptation (physiothérapie et/ou kinésithérapeute)	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
Médecine traditionnelle	1 Oui 2 Non	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
Organisme communautaire qui donne des services de santé Nom de l'organisme: _____	1 Oui 2 Non Si la personne a répondu non à toutes les réponses mentionnées ci-haut, passez à 45	1 1 fois 2 2 à 5 3 6 à 9 4 10 et plus 5 J'ai tenté mais je n'ai pu y accéder 98 ne sait pas	_____ __$ 98 ne sait pas
44. Pourquoi avez-vous consulté davantage la/le/ l' _____(le (s) service(s) que la personne a consulté le plus en 41- 42 apparaît)	Textuel:		

SITUATION SOCIO-ÉCONOMIQUE

Je vais maintenant vous poser quelques questions sur votre travail, votre revenu et votre logement actuel. Il est important pour nous de connaître la situation de vie et de travail des personnes sans assurance médicale puisque ces conditions ont un impact sur la santé. Il peut y avoir certaines questions qui sont très personnelles.

HISTOIRE PROFESSIONNELLE

45. Quel est le	Textuel:

métier que vous avez exercé dans votre pays d'origine?	_____ 0 Ne s'applique pas 99 pas de réponse
46. Dans les trois derniers mois, avez-vous… Lire toutes les options jusqu'à obtenir une réponse positive Si la personne répond 1 à 2, passez à 47 Pour 3 à 8, passez à 54	1 travaillé et reçu un salaire 2 travaillé sans être payé/bénévolat 3 cherché un emploi 4 étudié 5 pris soin des enfants et de la maison 6 véçu de votre pension 7 été temporairement incapable de travailler 8 été incapable de travailler puisque vous ne pouvez plus travailler 97 autre, spécifiez_____ 99 pas de réponse

CONDITIONS DE TRAVAIL

47. Depuis combien de temps occupez-vous votre emploi principal actuel? En mois 0-120	☐☐☐ Mois

En commençant par l'emploi où vous travaillez le plus d'heures, dites-moi…

48.Quel est votre titre d'emploi? 48-49 pour chaque emploi 0-10 lignes Mettre l'option passez à la question 50 à chaque ligne	49. En moyenne combien d'heures par semaine y travaillez-vous? 0-90
1.	☐☐☐
2.	☐☐☐
3.	☐☐☐
4.	☐☐☐

5.	☐☐☐
50.Quel énoncé décrit le mieux le type de contrat de travail pour votre emploi principal? Cochez une seule réponse	1 sur appel/ travail à la journée 2 contrat temporaire/ moins d'un an 3 contrat temporaire/une année ou plus 4 travailleur autonome, sans employé 5 travailleur autonome avec employés 6 contrat permanent, nombre d'heures variable 7 contrat permanent à temps partiel (moins de 30 heures par semaine) 8 contrat permanent à temps plein (30 heures ou plus par semaine) 99 pas de réponse
51. Travaillez-vous pour une agence de placement qui loue vos services à une autre entreprise?	1 Oui 2 Non 98 ne sait pas 99 pas de réponse
52. **Au cours de la dernière année**, avez-vous subi dans votre emploi principal actuel, de la violence physique, du harcèlement et/ou de gestes ou paroles à caractère sexuel?	1 Oui 2 Non 98 ne sait pas 99 pas de réponse
53**.** Avez-vous pu obtenir un permis de travail?	1 Oui 2 Non 98 ne sait pas 99 pas de réponse

RAISONS DU NON-EMPLOI

54. Avez-vous travaillé depuis votre arrivée au Québec? Q55 remplie pour tous	1 Oui Après 55, Passez à 56 2 Non Après 55, Passez à 63 99 Pas de réponse
55. Quelle est la raison principale pour laquelle vous n'occupez pas un emploi en ce moment?	1 difficulté à trouver un emploi 2 un autre membre de la famille travaille, ce n'est pas nécessaire pour moi de travailler 3 accident, blessure ou maladie reliée à mon travail actuel 4 accident, blessure ou maladie reliée à un travail antérieur 5 mon état de santé (pas relié au travail) 6 en raison de mon statut migratoire 97 autre, spécifiez_____ 99 Pas de réponse

LÉSIONS PROFESSIONNELLES

56. Dans *la dernière année*, avez vous eu un accident au travail, avec blessure (grave ou légère), ayant entraîné une conséquence physique ou psychologique?	1 Oui 2 Non 98 Ne sait pas 99 Pas de réponse
57. Dans la dernière année, avez-vous ressenti des douleurs importantes qui vous ont dérangé (e) durant vos activités et qui sont reliées à votre emploi? Cochez toutes les réponses qui s'appliquent. Demander à la personne de décrire le/ les endroit (s) du corps où elle a ressenti les douleurs	1 Oui , au cou 2 Oui, au dos 3 Oui, aux membres supérieurs, c'est-à-dire aux épaules, bras, coudes, avant-bras, poignet ou mains 4 Oui, aux membres inférieurs, c'est-à-dire aux hanches, cuisses, genoux, jambes, mollets, chevilles ou pieds 5 Non 98 Ne sait pas 99 Pas de réponse
58. Combien de blessures, d'accidents, de maladies que vous avez eu, sont directement liés à un emploi occupé au Québec? 0-20	☐☐☐

Pour toutes les situations survenues ou étant liées à un travail au Québec dans la dernière année…

59 à 62 avant de passer au suivant

Mettre l'option passez à 63 pour chaque ligne

59. Décrivez-moi la blessure, l'accident ou la maladie:	60. Quelle a été la durée de l'arrêt de travail ?(jours)	61. Avez-vous consulté un médecin?	62. Quelle assurance médicale aviez-vous à ce moment?
Textuel:	1 J'ai perdu	1 Oui	1 RAMQ

	mon emploi 98 ne sait pas 0-365 La réponse en chiffre doit apparaître d'abord, pour tous | | | |	2 Non 98 ne sait pas	2 PFSI 3 privée 4 aucune 98 ne sait pas
Textuel:	1 J'ai perdu mon emploi 98 ne sait pas 0-365 | | | |	1 Oui 2 Non 3 ne sait pas	1 RAMQ 2 PFSI 3 privée 4 aucune 98 ne sait pas
Textuel:	1 J'ai perdu mon emploi 98 NSP 0-365 | | | |	1 Oui 2 Non 3 ne sait pas	1 RAMQ 2 PFSI 3 privée 4 aucune 98 ne sait pas
Textuel:	1 J'ai perdu mon emploi 98 NSP 0-365 | | | |	1 Oui 2 Non 3 ne sait pas	1 RAMQ 2 PFSI 3 privée 4 aucune 98 ne sait pas

Les questions suivantes concernent votre ou vos sources de revenu. L'information donnée dans cette section servira à établir le portrait économique des personnes sans assurance médicale. L'information que vous allez nous donner demeurera confidentielle.

REVENU

63. Quelles sont toutes vos sources de revenus familiales? Cochez toutes les réponses qui s'appliquent	1 emploi/travail rémunéré 2 prestation d'assurance emploi 3 prestation d'assistance ou d'aide sociale 4 prêts et bourses scolaires 5 CSST 6 Revenus de pension de retraite 7 aide financière de votre famille ou amis 8 épargne

	10 aucun revenu Passez à 65 97 autre, spécifiez_____
64. Quel est le revenu mensuel de votre famille? Si la personne n'arrive pas à répondre, demandez-lui de faire une moyenne des trois derniers mois, ou de calculer le salaire de chaque personne séparément	1 Moins de 500 $ 2 De 501 à 1000$ 3 De 1001 à 1500$ 4 De 1501 à 2000$ 5 De 2001 à 2500$ 6 De 2501 à 3000$ 7 De 3001 à 3500$ 8 De 3501 à 4000$ 9 De 4001 à 4500$ 10 4501$ et plus 98 Ne sait pas 99 Ne souhaite pas répondre
65. Dans quelle mesure vos revenus vous permettent de satisfaire à vos besoins et à ceux de votre famille? Par besoins, je veux dire le logement, la nourriture, les vêtements, le transport et les soins de santé (médicaments, etc)	1 pas du tout 2 un peu 3 assez bien 4 très bien 5 parfaitement
66. Dans la dernière année, vous est-il arrivé de manquer de nourriture pour vous et votre famille et de manquer d'argent pour acheter le nécessaire?	1 Souvent 2 Parfois 3 Jamais 98 Ne sait pas 99 Pas de réponse

Les questions suivantes portent sur votre situation de logement.

LOGEMENT

67. Combien de fois avez-vous déménagé depuis votre arrivée au Québec? 0-30	☐☐☐
68. Lequel des choix suivants décrit le mieux votre lieu de résidence actuel?	1 Immeuble de 10 logements et plus 2 Immeuble de 4 à 9 logements 3 Duplex et triplex 4 Maison en rangée ou semi-détachée 5 Maison individuelle 6 Maison de chambre 97 Autre, spécifiez_____

69. Etes-vous (ou un membre de votre ménage) :	1 propriétaire? 2 locataire (même si aucun loyer en argent n'est versé)? 98 ne sait pas
70. À l'exception de la salle de bain, combien de pièces posède votre lieu de résidence?	1 1 2 2 3 3 4 4 5 5 6 6 4 7 5 8 6 9 et plus
71. Avec combien de personnes habitez-vous? 0-30 72. Avec qui habitez-vous? Inscrivez le nombre de personnes à l'endroit approprié 0-30	☐☐☐ (si 0, passez à 73) Nombre de… 1 Partenaire /époux (se) - _____ 2 Enfant(s) _____ 3 Petit (s)-enfant (s) _____ 4 Parent(s), frère(s) et sœur(s) _____ 5. Parent(s), frère(s) et sœur(s) du partenaire _____ 6. Ami (e/s) _____ 7. Colocataire(s) _____ 97. Autre, spécifiez _____
73. Combien d'argent dépensez-vous **chaque mois** pour vous loger et pour payer les services associés (électricité, chauffage)?	1 Moins de 500 $ 2 De 501 à 1000$ 3 De 1001 à 1500$ 4 De 1501 à 2000$ 5 De 2001 à 2500$ 6 De 2501 à 3000$ 7 De 3001 à 3500$ 8 De 3501 à 4000$ 9 De 4001 à 4500$

	10 4501$ et plus 98 Ne sait pas 99 Ne souhaite pas répondre
Il y a beaucoup de logements à Montréal qui ont des problèmes d'infestation ou de salubrité.	
74. **Dans la dernière année**, avez-vous remarqué les situations suivantes dans votre logement: Cochez toutes les reponses qui s'appliquent	1 présence de coquerelles 2 présence de punaises de lit 3 présence de souris 4 présence de rats 5 présence d'odeur ou de taches de moisissures (sauf une petite quantité près des fenêtres et du bain) 6 présence d'inflitration d'eau (taches ou cernes jaunis sur les plafonds, les murs ou ailleurs) 7 inondation ou dégât d'eau 97 autre, spécifiez_____

SOUTIEN SOCIAL ET COMMUNAUTAIRE

Les questions suivantes concernent le type de soutien qui vous est offert par votre famille et votre entourage.

75. Est-ce que vous avez quelqu'un avec qui vous pouvez partager vos préoccupations ?	1 Oui 2 Non Passez à 77 98 Ne sait pas 99 Pas de réponse
76. Avec combien de personnes pouvez-vous le faire? 0-30	☐☐☐
77. En cas de nécessité, avez-vous quelqu'un dans votre entourage qui peut vous prêter de l'argent?	1 Oui 2 Non 98 Ne sait pas 99 Pas de réponse

MIGRATION ET AJUSTEMENT SOCIAL

La prochaine section concerne votre experience de migration au Québec, ainsi que le stress et l'inquiétude qui peuvent y être associés. L'information que vous allez nous donner ne pourra pas être retracée et demeurera confidentielle. Nous savons que les prochaines questions peuvent vous ramener à des évènements difficiles, prenez tout le temps nécessaire pour répondre. Vous pouvez interrrompre les questions à tout moment. Cette

information est importante pour nous permettre de mieux comprendre votre réalité.

RÉGULARISATION DU STATUT

78. Quel est votre statut migratoire aujourd'hui?	1 Résident permanent 2 Demandeur du statut de réfugié 3 Travailleur étranger temporaire ou dépendents 4 Étudiant ou dépendents 5 Visiteur 6 Autre résidence temporaire (ex.Super Visa) 7 En attente de statut (application faite, en attente d'une réponse) 8 Aucun (aucune application en cours) 97 Autre visa, spécifiez:_____ 98 Ne sait pas 99 Ne souhaite pas répondre
79. **Dans la dernière année,** à qui avez-vous demandé conseil à propos de votre situation d'immigration ? Cochez toutes les réponses qui s'appliquent Indiquer l'ordre des instances/ personnes consultées 1 à 7	__ Avocat __ Consultants en immigration __ Centre de santé et services sociaux (CLSC, Hôpital) __ Organisme communautaire __ Organisme privé d'aide à l'immigration __ Famille, ami, connaissance __ Aucune personne, aucune institution Passez à 81 97 autre, spécifiez_____ 99 Ne souhaite pas répondre Passez à 81
80. Combien d'argent vous dépensé pour réaliser vos démarches migratoires? Arrondir au dollar près 0 à 50 000	1 Moins de 500 $ 2 De 501 à 1000$ 3 De 1001 à 1500$ 4 De 1501 à 2000$ 5 De 2001 à 2500$ 6 De 2501 à 3000$ 7 De 3001 à 3500$ 8 De 3501 à 4000$ 9 De 4001 à 4500$ 10 4501$ et plus 98 Ne sait pas 99 Ne souhaite pas répondre

ÉCHELLE DE STRESS MIGRATOIRE

La section suivante porte sur différentes situations qui sont parfois vécues par les personnes qui n'ont pas d'assurance médicale et le niveau de stress qui s'en suit.

81. Dans **les 3 derniers mois**, dans quelle mesure les situations suivantes vous ont causé du stres

Inclure échelle de couleur dégradé de rouge (si possible)	0 Cette situation ne m'a jamais causé de stress	1 Pas du tout	2 Un peu	3 Modérément	4 Beaucoup	5 Extr me
a) avoir le besoin de parler mieux en français ou en anglais						
b) travailler loin de ma famille pour gagner ma vie						
c) la peur de perdre mon travail au profit d'immigrants arrivés plus récemment						
d) l'impression d'avoir subi de la discrimination au travail						
e) des amis ou de la famille qui m'ont dit que je suis devenu trop occidentalisé ou trop canadien						
f) avoir de la difficulté à combiner ma culture d'origine à la culture canadienne dans la famille						
g) avoir l'impression d'être discriminé lors de ma recherche de soins de santé						
h) être inquiet de ne pas savoir comment ma famille et moi allons recevoir les soins de santé nécessaires						
i) entendre les autres dire des commentaires comme: retourne dans ton pays!						
j) rencontrer un agent de police						
k) avoir des difficultés à trouver un travail à cause de mon statut d'immigration						
l) avoir des difficultés à trouver l'emploi qui me plait en raison de mon statut d'immigration						
m) être témoin de trop de violence dans ma communauté						
n) avoir l'impression qu'il						

m'est plus difficile de réussir en raison de mon origine						
SECTION UNIQUEMENT POUR LES PERSONNES EN ATTENTE DE STATUT ET SANS STATU Inclure la possibilité de passez directement à la Q82						
o) être inquiet que moi, ma famille ou mes amis aient des problèmes avec l'immigration (services frontaliers)						
p) rencontrer un agent d'immigration						
q) rencontrer/ avoir des demandes d'une personne à qui je dois de l'argent pour mon immigration						
r) avoir peur d'aller à l'hôpital ou voir un médecin en raison de ma situation migratoire						
s) avoir le sentiment que je vais être déporté si je vais dans les services publics						
t) avoir des contacts limités avec ma famille et mes amis en raison de mon statut migratoire						

EXPÉRIENCE POSITIVE AU QUÉBEC

82. Quels sont les aspects positifs de votre expérience au Québec?	Textuel :
83. Quelles sont vos suggestions pour améliorer la situation des personnes migrantes sans assurance médicale?	Textuel :

FIN DU QUESTIONNAIRE