

**Asylum and the Politics of Irregularization:  
Refugee Claimants and Toronto's Everyday Places**

by

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## **Author's Declaration**

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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## **Abstract**

While Canada is touted as having a universal healthcare system, not all of its residents have access to it, particularly precarious status noncitizens such as refugee claimants. As a signatory of international refugee accords, Canada is obligated to ensure that refugee claimants within its borders receive access to healthcare. However, from June 2012 to April 2016, refugee claimants received restricted access to healthcare coverage offered through the Interim Federal Health Program (IFHP). While the underlying goal of this move was to regulate refugee claimants within and outside of the country, it had a major unintended consequence; within everyday healthcare places like hospitals, walk-in clinics, and doctor's offices, many refugee claimants were denied access to healthcare services regardless of actual levels of coverage. This was due to the relations and encounters between various elements and actors, which produced inconsistent, unpredictable, and contradictory experiences. In this dissertation, I analyze this program and resulting everyday experiences through the lens of irregularization, a regulatory assemblage that problematizes the presence of persons/groups within space and attributes an identity of irregularity, referred to here as an irregular status, that reflects one's constructed abnormal or problematic presence within space.

I build this argument in relation to existing critical migration scholarship, particularly scholarship that engages with borders, (non)citizenship, and humanitarianism. Through these important critical lenses, we are made aware of how identities and subject positions are created and how migrant and refugee populations are regulated locally, nationally, and transnationally. To ground this argument empirically, I provide a policy and discourse analysis of relevant media, position papers, and policy documents to shed light on the tense socio-political context during this time and the everyday workings and implications of irregularization. In addition to this

analysis, I also conducted semi-structured interviews in order to highlight the voices of key actors on the ground within the city of Toronto: doctors, lawyers, executive directors, program managers, Ministry officials, City officials, and refugee claimants. This methodology helps to demonstrate how the assemblage of irregularization is constituted and operates, and how borders, (non)citizenship, and humanitarianism can be conceived of as irregularizing assemblages that problematize presence within space, produce insecurity and anxiety, and affects the well-being of refugee claimants in Canada.

In addition to a focus on regulation, I also analyze the friction that constitutes the assemblage of irregularization. During this time from 2012 to 2016, the city of Toronto witnessed demonstrations, campaigns, and occupations to draw public attention to the IFHP cuts and the experiences of refugee claimants, in addition to less visible acts that established ‘common’ spaces which prioritize the health of refugee claimants and others present within the city. Drawing on critical citizenship scholarship, I analyze these challenges through the concept of *acts of liberating irregularity*, being the visible and less visible deeds or conducts that are enacted through solidarity and performativity to assert the presence of refugee claimants and the right to healthcare. While these acts were not necessarily transformative, they were important in addressing the healthcare needs of refugee claimants, and offering a subtle resistance to the irregularizing assemblages of borders, citizenship, and humanitarianism. In this critical analysis of the politics of irregularization, this dissertation contributes to the sociology of migration as it relates to regulation and resistance, and offers a timely and unique analysis of Canada’s refugee healthcare system as defined by the IFHP.

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## Table of Contents

1. List of Abbreviations	ix
2. Introduction	1 - 17
3. “There’s Nothing Illegal About Being a Refugee Claimant”: An Argument for the Conceptual Expansion of Irregularization	18 - 46
4. The Irregularizing Assemblage of Bordering: Borderzones, Borderwork, and Acts of Liberating Irregularity	47 - 75
5. The Irregularity of Refugee Claimant (Non)Citizenship: Discrimination and Solidarity in Toronto’s Everyday Healthcare Places	76 - 108
6. In the Name of Humanitarianism: The Interim Federal Health Program and the (Affirmative) Politics of Irregularization	109 - 138
7. Conclusion	139 - 152
References	153 - 174



## **List of Abbreviations**

CHC	Community Health Centres
DCO	Designated Country of Origin
H&C Claim	Humanitarian and Compassionate Claim
IFHP (or IFH)	Interim Federal Health Program
OHIP	Ontario Health Insurance Plan
OTHP	Ontario Temporary Health Program
PHPS	Public Health Public Safety
RPCD	Refugee Protection Claimant Document

## Chapter 1

### Introduction

One day in October 2015, I was sitting in a dark and congested waiting room in a settlement facility in downtown Toronto prepping for my interview with an intimidating and overworked settlement counsellor. Suddenly, a loud voice boomed across the room in my general direction. *‘Hey you, you’re interested in the IFHP right? Come here.’* I was there to learn about this program, and to come to terms with how it is situated within the broader context of migration management. I walked into the room where the counsellor sat with a distraught refugee claimant. She was there seeking clarification on why her young son, who had severe allergies and required weekly blood tests, no longer received healthcare coverage. The woman spoke very little English and was unable to understand the dense, tiny print on the Refugee Protection Claimant Document that detailed her son’s coverage through the Interim Federal Health Program (IFHP). The counsellor went on to explain to the woman and myself that the child’s IFHP coverage had expired after 12 months. There was no notification. She had to reapply for coverage for her son, which could take up to 3 months. In the meantime, she and the counsellor had to seek out a doctor who would be willing to detail the severity of the case to Citizenship and Immigration Canada in order for the child to receive what is termed section 7 coverage—a form of coverage offered by the Minister of Immigration in exceptional and compelling circumstances. As she left the room, I could not help but think of the injustice this woman’s son was facing—the denial of a simple blood test. *How is this happening in a country like Canada, which flaunts its universal healthcare system and its treatment of refugees?* As she left the room and I set up my recorder and documents, the counsellor stated, *‘we take in refugees, but we victimize them again by not providing them medical. What kind of a country is this?’*

The above story is one of countless examples of how the lives of refugee claimants<sup>1</sup> in Canada, from 2012 to 2016, were impacted through regulatory efforts embedded in the cuts made to the Interim Federal Health Program (IFHP). Introduced in 1957, the IFHP is a federal health insurance program that offers basic healthcare coverage<sup>2</sup>, prescription coverage, and

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<sup>1</sup> A refugee claimant is “someone whose request for sanctuary has yet to be processed” by a national asylum system. This system determines who does and does not qualify for protection (UNHCR).

<sup>2</sup> Hospital services, services from a healthcare professional, pre- and post-natal care, laboratory, diagnostic, and ambulance services.

supplementary coverage<sup>3</sup> to refugee populations in Canada; this coverage is similar to that provided to citizens and permanent residents on social assistance. In June 2012, the program was drastically amended to significantly restrict or deny coverage to refugee claimants and other refugee populations, which reflected a broader securitized context that problematized the movements and presence of refugee populations in Canada.<sup>4</sup> As made evident in the Charter challenge that was launched against the Federal government, the underlying goals of the IFHP cuts were to deter ‘bogus’ refugee claimants from making an asylum claim within the country, and to make life so intolerable that refugee claimants in Canada would be forced to leave (Canadian Doctors for Refugee Care et al. v. Canada 2014:7–8). However, what emerged from these cuts was a major “unintended consequence” that came to impact the everyday lives of refugee claimants (Interview with Policy Analyst, 21 October 2015, Toronto). Due to the confusion surrounding the program and the various constructions and discourses of refugee claimants, in addition to various other relations and encounters, everyday healthcare professionals came to inconsistently, unpredictably, and contradictorily problematize the presence of refugee claimants within everyday healthcare spaces, such as walk-in clinics, hospitals, and doctor’s offices, regardless of coverage.

At the time of the above interview, protests and campaigns had already drawn critical public attention to the implications of the IFHP cuts on the lives of refugee claimants, and the Conservative federal government had been brought to court by refugee claimants and allies, resulting in an unprecedented court ruling that deemed the government to be subjecting refugee

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<sup>3</sup> Limited vision and urgent dental, home and long-term care, assistive devices, and services from allied healthcare practitioners such as psychologists or therapists.

<sup>4</sup> This is evident for example in the *Immigration Refugee and Protection Act* (IRPA) in 2002, the *Balanced Refugee Reform Act* (BRRA) in 2010, and the *Protecting Canada’s Immigration System Act* (PCISA) in 2012 (Atak et al. 2017; Huot et al. 2015; Jimenez and Crepeau 2013).

claimants to ‘cruel and unusual treatment’ (Canadian Doctors for Refugee Care et al. v. Canada 2014:8). Furthermore, at the time of the above interview, the government had (unwillingly) introduced a ‘temporary’ IFH program which reinstated full coverage to women and children, but continued to maintain the restrictions and hierarchical categorizations that defined the 2012 program, along with the confusion and unintended, unpredictable, and contradictory outcomes of seeking out and gaining access to healthcare services. However, what had not yet happened was the outcome of the federal election.

In August 2015, Prime Minister Stephen Harper dissolved Parliament for a general election to be held on October 19, 2015. His main opponents, Justin Trudeau of the Liberal Party and Tom Mulcair of the New Democratic Party (NDP) ran on a platform of enhanced refugee rights, including the reinstatement of the IFHP (Liberal Party of Canada 2015:65; NDP 2015:8-9). On October 19, Justin Trudeau and the Liberals won a majority government. They dropped the court appeal of the IFHP<sup>5</sup>, reinstated the program to its pre-2012 coverage levels in April 2016, and expanded coverage in April 2017 to refugees who are currently overseas awaiting resettlement to Canada. This dissertation focuses on the IFHP cuts from 2012 to 2016, and aims to come to terms with the justification of restrictive measures in the context of refugee healthcare. I situate this analysis in the city of Toronto and its everyday healthcare places to make visible the connection between regulation and everyday life. Toronto offers a rich site in which to conduct this research due to its size, and specifically, due to the number of networks, refugee (health) experts, and refugee claimants located in the city (City of Toronto 2017).

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<sup>5</sup> The Conservative government appealed the 2014 Court decision to introduce a revised and more inclusive IFH program.

Analyzing the IFHP through a regulatory lens, this dissertation draws critical and timely attention not to how the legal status of refugee claimants changed in ways that effected healthcare coverage (see Goldring et. al 2009; Goldring and Landolt 2013 on precarious noncitizenship status) but rather how their presence was problematized in ways that justified the IFHP cuts. By presence, I mean ‘being here’, or one’s concrete locality within and occupation of space. Presence is affiliated with recognition and rights, meaning the targeting and questioning of presence interrupts rights associated with it (Rygiel 2011a:13-14; chapter 2). To have one’s presence problematized results in a positioning or the attribution of an identity that denies the right to make claims within space. I understand this positioning as irregular status. Reflecting a type of subjectification process that forms human beings as subjects for the purpose of regulation and that limits access to social resources, irregular status reflects one’s constructed problematic and abnormal (or irregular) presence within space and significantly affects life chances.

Irregular status emerges via an assemblage of various elements, including knowledges, encounters, policies, documents, practices, actors, etc., that I define as irregularization. Building off the work of Hepworth (2014) and Squire (2011), irregularization is an assemblage of heterogeneous elements that come together in unpredictable and contradictory ways to problematize the presence of persons such as refugee claimants as ‘out of place’, abnormal, or otherwise irregular. What makes this approach unique from others (Hepworth 2011; Johnson 2014; McNevin 2006; Squire 2011) is the emphasis placed upon assemblage, presence, irregular status as a nonjuridical positioning, and abnormality (rather than illegality) in relation to legal authorized temporary residents. In this regard, this dissertation both complements and expands upon existing critical migration scholarship through a conceptual expansion of key terms in the literature, and as a result, offers critical sociological insight on Canada’s asylum context and its

IFH program. Furthermore, to approach irregularization as an assemblage highlights how and why exercises of power emerge in particular ways, how they are (precariously) held together, how they shape space and action, and how they ‘fall apart’ (see Müller 2015:27). It allows for the conceptualization of irregularization as contradictory, unpredictable, and inconsistent and as producing new and unexpected realities. The usefulness of assemblage within critical migration scholarship has been noted by scholars in their analysis of Canada’s everyday illegalizing ‘surveillant assemblages’ (Villegas 2015), the ‘humanitarian border’ that surveils and polices humanitarian subjects (Walters 2011a), and humanitarian aid within Namibia’s Osire refugee settlement which shape the space of the camps and the conduct of those residing within it (Ilcan 2013). However, to engage with assemblage also alerts us to the friction that constitutes it (Ilcan 2013). I approach such struggles through the concept of acts of liberating irregularity.

Building off of acts of citizenship literature (Isin 2008; Isin and Neilson 2008) and ideas of commoning (Anderson et al. 2009, 2012; Casas-Cortés et al. 2014a), acts of liberating irregularity speaks to the various visible and less visible deeds that, through solidarity and performativity, resist and challenge irregularity. These acts assert the presence of refugee claimants and a right to be free from the discrimination that constitutes irregularity. The type of re-founding presence that defines acts of liberating irregularity is reminiscent of Johnson’s (2015:958) concept of ‘re-taking presence’, which challenges existing criteria for being present by “populating the ‘space’ of society” with ‘other’ subjects”. Through acts of liberating irregularity, actors enact themselves as political subjects, which I conceive of as ‘common’ subjects, who reject discrimination and the enclosure of space in favour of ‘common’ spaces defined by mutuality, respect, and equity (see chapter 2) or are subjectified in political ways by allies (see Castañeda 2013; see chapter 4). This concept offers numerous contributions to the

literature. It does not construct political subjects as transformative actors, nor does it romanticize the precariousness of refugee populations (Johnson 2012; Landolt and Goldring 2015; Pasquetti 2015). Acts of liberating irregularity also attends to the importance of solidarity specifically within securitized contexts (Johnson 2012, 2014) and complements calls to consider less visible everyday acts (Ataç et. al 2015). Finally, it contributes to arguments on the implications of ‘citizenship’ (i.e. acts of citizenship) in analyses of noncitizen activism (Johnson 2015; Tambakaki 2015; Tonkiss and Bloom 2015). While these acts are not so much ‘transformative’ as they are ‘affirmative’ (see Fraser 2008:22-24; see chapter 5), their overall importance is evident in how they contest Canada’s regulatory asylum context. It is this politics of irregularization, being the contestation, tension, and disagreement, that this dissertation analyzes.

In order to better understand irregularization, I engage with the concepts of borders (DeGenova 2013; Rumford 2006, 2012), (non)citizenship (Isin 2002; Isin and Neilson 2008; Johnson 2012; Landolt and Goldring 2013), and humanitarianism (Fassin 2010; Malkki 1996; Ticktin 2011a), to which I respectively dedicate 3 empirical chapters (chapters 3-5). These concepts alert us to the regulation of migrant and refugee populations, and the construction of difference (as something/someone different from the norm). Briefly, borders emerge whenever and wherever selectivity and verification controls are found, which gives rise to various categorizations and/or reduced pathways to rights; citizenship is an articulation of an identity that emerges in relation to otherness and which justifies the privileging of rights for some people over others; and humanitarianism identifies, classifies, and manages populations deemed to be in need of protection and assistance in ways that create hierarchies of legitimacy and deservingness. Each chapter offers a response to the overall research question guiding this dissertation project, which is: how can we conceive of the politics of irregularization within Canada’s asylum

context? How are refugee claimants irregularized and how is irregularity experienced within the everyday spaces that refugee claimants inhabit and/or move through? Finally, how is irregularization/irregularity resisted? Drawing on critical migration scholarship, this dissertation offers responses to these questions in ways that alert us to new modes and exercises of regulation for different types of populations, the complexity and contradictions of irregularization, and the implications that irregular status can have on everyday life, including life-threatening ones.

### Methodology

Research for this dissertation comprised of semi-structured interviews with 43 participants in Toronto, Ontario, from September 2015 to March 2016. Participants included doctors, nurses, lawyers, settlement workers, policy specialists, Executive Directors and Program Managers of refugee agencies, Ministry officials, City officials, and refugee claimants. The large majority of the participants were contacted through email and cold-calling, while some were secured through referral. I relied upon academic and grey literature to identify key actors and organizations as well as a general Google search for refugee claimant organizations and refugee/un(der)insured healthcare providers in Toronto. Interviews lasted an average of 45 minutes and were conducted in a variety of settings: public libraries, refugee agencies, homes, offices, and occasionally by telephone. The interviews were audio-recorded and transcribed to ensure accuracy. Prior to the interview, participants signed, or verbally agreed to, a consent form that informed them of their rights, confidentiality, and anonymity throughout the research project. The purpose of the interview was to gain a grounded understanding of the IFHP and the experiences of refugee claimants within everyday healthcare places, while allowing participants the freedom to express their own interpretations, judgments, and experiences with the program and refugee health and



wellbeing. Throughout the interview, narrative and individual experiences of the participant were prioritized to reveal the consequences of policy and practice and the effects of irregularity in everyday life (Johnson 2014:206).

With regards to contacting refugee claimants, I relied upon participants who worked with this population to send out information sheets. The sheet detailed the goals of the project and provided my contact information so that refugee claimants could contact me without the knowledge of agency workers. Due to concerns regarding privacy and security, two participants did not send out this form. One participant successfully sent out the information sheet and took it upon him/herself to set up a meeting between their clients and myself in the basement of the refugee shelter without the presence of agency workers. Initially set at a two or three-person interview, the result was a ten to eleven person focus group (persons were coming and going throughout the interview) consisting of eight to nine men, and two women, with ranging ages and countries of origin. All participants had been in the country for four months or less and were able to converse in English.

The focus group setting provided interesting dialogue amongst the group, and an opportunity to learn from each other. However, like any multi-person setting, some of the timid participants, including the two women, were less willing to participate in the conversation. The focus group is a fitting method since, due to time limits, I was unable to establish trust with the refugee claimants prior to our meeting. As Houston et al. (2010) note, when trust is absent, focus groups allow researchers to access information from a larger number of people in a shorter period of time (287) “in a safe and supportive environment [...] especially because certain groups, such as refugees, often carry a deep suspicion of the state and university researchers” (286; see Block et al. 2012:81). Also, because I was speaking with a marginalized group of

people, the non-hierarchical nature of the focus group “shift[s] the balance of power away from the researcher towards the research participants” (Wilkinson 1999:64, cited in Houston et al. 2010:287). Overall, there were no potential risks or ethical concerns regarding participation in this study, as stated by the University of Waterloo’s Research Ethics Board. The names of refugee claimants were not recorded, nor were their countries of origin or any other personal identifiers. Participants were provided with a consent form, and were read the consent form in clear and simple terms. They had the opportunity to ask questions about the project before, during and after the interview, were made aware of the fact that they could choose not to respond to questions if they felt uncomfortable, and that their choice to participate would not affect their relationship with their organization (Block et al. 2012:73-74, 80; Hugman et al. 2011:1277-1278). Participants were also made aware that the focus group should be likened to a knowledge sharing session on issues regarding access to healthcare and other issues they deemed relevant to daily life, and that the discussion would not necessarily lead to policy change, but rather would assist in spreading the word regarding the experiences of refugee claimants in Canada, and of the IFHP specifically.

My interview questions for all of the participants focused largely on understandings, interpretations, and experiences of the IFHP, provincial and local healthcare and refugee rights initiatives, and healthcare services in the city that treat or do not treat refugee populations with IFHP coverage. In order to deepen my understanding of the workings of and resistances to refugee regulation in the Canadian context, I also questioned how participants thought barriers and challenges in the healthcare context were produced, (re)negotiated, or transgressed; this also helped to expand my understanding of traditional and non-traditional expressions of resistance

and ‘momentary’ politics (Johnson 2014). Interviews were transcribed and read several times, with emerging themes, commonalities, and conceptual links noted.

In addition to the interviews, I also employed discourse and policy analysis of relevant governmental and non-governmental statements, press releases, policy documents, position papers, and reports. I employed policy analysis to draw attention to “the making, mobilization, and implementation of policy” (Baker and McGuirk 2017:5), and discourse analysis to consider “how social experience is created and given meaning” (Denzin and Lincoln 2011:8). For example, Johnson (2011) utilizes discourse analysis in her research on the shifting imagination of the refugee via policies and practices, while other scholars have employed discourse analysis to highlight the construction of refugee claimant subjectivity (Lacroix 2004), specifically in the post-2012 context (Diop 2014; Huot et al. 2016). In relation to the IFHP, Beatson (2016); employs this method to demonstrate the different articulations of refugee claimants by allies and the federal government that simplify the complex realities of this population and obscure rights-based arguments for healthcare. I draw from these analyses in my own research.

My methodology also complements my conceptual approach to irregularization as an assemblage. Employing an iterative approach that develops emerging themes in unintentional ways, I highlight how encounters, actors, knowledges, logics, policies, practices, etc. come together to effectively problematize presence and produce restricted pathways to healthcare. This iterative methodology complements assemblage by drawing attention to multiplicity, complexity, and contingency (see Baker and McGuirk 2017:5) and to the labour<sup>6</sup> that goes into the regulation of migration (see Walters 2011:5). In this way, my methodology challenges notions of linearity,

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<sup>6</sup> Labour is refers to “the continued efforts of human actors and the enrolment and often unforeseen effects of various materials and techniques” (Baker and McGuirk 2017:8).

stability, and solidity assumed by ‘governance arrangements’ (Walters 2017) by embracing the messiness of regulation and control as it is (re)/made and (re)/negotiated in the everyday.

### **Outline of the chapters**

The dissertation is divided into six chapters. In the next chapter (chapter 2), I provide an outline of my conceptual framework which builds upon critical migration scholarship in the fields of sociology, anthropology, geography, and political science. Engaging with the existing influential concepts of illegalization (DeGenova 2002, 2013) and irregularization (Hepworth 2014; Johnson 2014; Squire 2011), I argue for an expanded approach to irregularization, one that does not focus on how migrant and refugee populations are ‘illegalized’ (McNevin 2006) but rather how, through targeting and questioning, presence is problematized in ways that constitute populations as abnormal, out of place, or otherwise irregular, regardless of legal status. By approaching irregularization in this manner, I see irregularity not so much as a condition or juridical status but a nonjuridical status, or rather a positioning (Turner 1989) or a type of subjectification process, that shapes the everyday lives of refugee claimants and how they access essential services such as healthcare. I elaborate on this conceptual expansion of irregularization and irregular status through an engagement with the concepts of borders, (non)citizenship, and humanitarianism. As a result, I demonstrate how they are implicated in the irregularization of marginalized populations and should therefore be conceived of as irregularizing assemblages. I conclude the chapter by discussing how irregularization is challenged through acts of liberating irregularity. Defined as deeds that aim to challenge irregularity through the assertion of presence, and the rejection of difference and enclosure, acts of liberating irregularity highlight how subjects enact themselves as political subject and the importance of solidarity and everyday less visible acts as

challenges to irregularizing assemblages. In this light, the key question guiding this chapter is, how can we conceive of the abnormal positioning of refugee claimants?

Chapter 3 represents the first of three empirical chapters dedicated to the irregularization of refugee claimants in Toronto's everyday healthcare places. Here, I draw upon existing border scholarship which alerts us to how borders are not so much things as doings that pervasively materialize within and beyond the state in (un)expected places so as to regulate movement via ranking, sorting, and filtering functions (DeGenova 2013; Menjivar 2014; Mezzadra and Neilson 2013). Essentially, borders work to "mark some bodies as legitimate and others as out of place" (Johnson and Jones 2011:61), a statement that mirrors irregularization. These markings reflect the creation of subjectivities that are differentially included within the border space (Mezzadra and Neilson 2012). In this regard, borders produce differentiation and stratification of not only legal statuses but also subjectivities that fundamentally influence "people's consciousness of who 'belongs'" (Sharma 2001:417-8). I approach these subjectivities as irregular status. My focus is on the internal border (Menjivar 2014) which continues to regulate refugee claimants and establish difference through new forms of stratification and subjectification, within the everyday. In my approach to borders through the lens of irregularization, I highlight how data, documentation, and everyday actors work to construct and identify irregularity within the everyday. To do this, I draw on the concepts of borderzones and borderwork. Building upon the work of Isin and Rygiel (2008), and Walters (2011), I understand borderzones as sites of homogenization and standardization that are situated within cities/towns to monitor and regulate populations in strategic everyday sites through mundane activities. I approach healthcare centres as borderzones, which operate as sites of standardization as noted through provincial health insurance plans, such as OHIP. Here, refugee claimants are irregularized as a result of IFHP data

and documentation, which differs from the standardized provincial health plan. Building on this, I also draw on Rumford (2006, 2012) to demonstrate how borders are performed, or rather made and dismantled by everyday people such as nurses, doctors, front-line staff, and hospital administrators through borderwork. For example, I analyze a case where a hospital administrator enforced an uninsured fee, which I understand to be a type of border practice, upon a refugee claimant from Mexico who had full coverage which led the woman to opt for a home birth. The irregularity that came to define refugee claimants was in fact so effective in a regulatory sense that cases exist of refugee claimants either avoiding seeking out care or rescinding their asylum claim. But the acts of liberating irregularity that I highlight in this chapter, such as the continued provision of care in certain places, word of mouth, and system navigation work, not only alert us to the constitution of refugee claimants as political subjects, but also to the importance of solidarity between refugee claimants and allies in these acts. In relation to the broader guiding research question of how we can conceive of the politics of irregularization, this chapter asks how are borders implicated in the irregularization of refugee claimants, and how is this irregularizing assemblage challenged?

With bordering a “defining and enduring feature” of noncitizens (DeGenova 2013:1188), chapter 4 focuses on (precarious) (non)citizenship (Landolt and Goldring 2013) to demonstrate its relation to irregularization. I draw on Isin’s (2002) work on citizenship, which alerts us to how the identity of the citizen emerges in relation to the other or the noncitizen, in order to establish a connection between the other and irregularity, and how this status is (re)/defined and (re)/constituted in the everyday (Hepworth 2014; Landolt and Goldring 2015). Here, I focus on the importance of encounters and the discrimination that emerges through them. My approach to citizenship as an irregularizing assemblage complements McNevin’s (2011:15-16) claim that

abnormality is very much a part of the history of citizenship. For example, I discuss how Immigration Minister Jason Kenney used ‘Canadianness’ to create difference between citizens and refugee claimants and justify restricted access to healthcare coverage; by defining who Canadians are and what Canadians stand for, a space was provided to imagine the ‘other-than-Canadian’ characteristics of refugee claimants (see Bains and Sharma 2002; Sharma 2001). This was reaffirmed through flyers and petitions sent out by Conservative politicians, who through a focus on fairness, created a scenario of Canadians as being taken advantage of by refugee claimants (Bolen 2012a, 2012b; CBC News 2015). In these examples, an interesting image of the refugee claimant emerge, one that is not only based upon the abnormality of their presence within spaces that prioritize citizenship, but also based upon division and conflict (see Isin 2002).

As one doctor states:

there was a lot of divisive rhetoric [...] not just Canadians versus migrants but also within the migrant community there’s a lot of division that’s been created between immigrants and refugees and this notion of people that have come through legitimate processes and less legitimate processes that are queue jumpers (Interview with Doctor, Toronto, 20 October 2015).

For this doctor, the division occurred not only between citizens and migrants (including refugee claimants) but also amongst refugees who were divided according to ideas of legitimacy and irregularity. This latter point is discussed in chapter 5.

In addition to focusing on this dialogical relationship of how the citizen is articulated in relation to the other and vice versa at the national level, I also focus on the everyday encounters between refugee claimants and service providers as important elements of irregularization (see Bhuyan 2012; Hepworth 2014; Isin 2002). These encounters alert us to how irregular status emerges and is modified in the everyday and how discrimination results from these encounters, reflecting Isin’s (2002:34) argument that otherness has a tendency to represent the worst

characteristics of citizens. However, Isin (2002:4) also draws attention to moments of ‘becoming political’, which challenge “categories, classifications, and identities of otherness”. While a great deal of the literature that focuses on such moments do so in relation to noncitizens who constitute themselves as de facto citizens, this chapter attends to how citizen allies constitute themselves as political subjects (see Castañeda 2013). Specifically, I highlight how allies use their citizenship to draw attention to, and undermine, the inequalities that constitute this status. In this regard, by focusing on (citizen) allies, this chapter places renewed focus on solidarity within broader understandings of acts and how allies enact themselves as political subjects. The key question guiding this chapter is how is irregularity a construct of the relationship between citizenship and noncitizenship, and who is the political subject that challenges irregularity/irregularization?

Considering that refugee claimants are humanitarian subjects, and that the IFHP operates as a humanitarian program, chapter 5 engages with humanitarianism as an irregularizing assemblage. Here, I approach the irregularization of refugee claimants in relation to the differences that define humanitarianism (Fassin 2010). Specifically, I consider how the irregularity of refugee claimants is produced through humanitarian systems—being Canada’s national asylum system—and how women have a specific experience of irregularity; this system offers a limited conceptualization of persecution which positions women in irregular ways. My approach to humanitarianism is shaped by Fassin’s (2010:239) argument that “humanitarianism is founded on an inequality of lives and hierarchies of humanity”. This is evident within refugee populations, and between refugees—who require protection—and their protectors (Fassin 2008; Ticktin 2006). I build on this perspective to establish a connection with irregularization. With regards to the former point, refugee claimants are divided from others due to how they access humanitarian systems, specifically, national asylum systems. Their agency, in seeking out



protection on their own, is constructed in ways that reflect unregulated movements, or what Nyers (2003:1070) terms an ‘unsavoury agency’. In this regard, I argue the manner in which refugee claimants gain access to the system is irregularized, resulting in increased targeting and questioning and the justification of restricted access to humanitarian programs or other programs offered to those navigating the asylum system. Drawing on Zetter’s (1999:2,8, cited in Chimni 2000:254) discussion on the importance of labels, which establish “assumptions and expectations about humanitarian treatment and responses”, the restriction of refugee claimants to humanitarian programs such as the IFHP reflects their irregularity and the expectation of the type of treatment they should be accorded. This is made evident in the very visible hierarchical positioning of refugee populations within 2012 and 2014 IFHP charts. On the latter point, regarding the inequality between protectors and those in need of protection, in the context of healthcare, the protector is the doctor. In their attempts to provide healthcare to refugee claimants, I argue that doctors perpetuate irregularity by reaffirming the irregularized status of refugee claimants. I highlight how this works by analyzing how section 7 coverage requires additional forms of evaluation that re-irregularize refugee claimants, and how demands of protestors (re)/irregularized other precarious status noncitizens, including the many refugee claimant women who are seeking access to protection through alternative pathways. Through this analysis, I argue that acts of liberating irregularity are more ‘affirmative’ than ‘transformative’ (Fraser 2008). I conclude the chapter with potential alternatives to Canada’s current humanitarian asylum system. The key question guiding this chapter is: how is Canada’s asylum system irregularizing, and are there gendered effects? I also ask how are the humanitarian actors who perform acts of liberating irregularity implicated in the continued irregularization of refugee claimants? The last chapter, chapter 6, concludes the dissertation by

providing an overview of the intentions of the project, contributions made, limitations, and recommendations for future research.

## Chapter 2

### **“There’s Nothing Illegal About Being a Refugee Claimant”: An Argument for the Conceptual Expansion of Irregularization**

In an era of unprecedented movement, states are seeking new and innovative ways to regulate the movement of people, specifically poorer and/or racialized persons through differential statuses that create and maintain inequality and nonmembership—what Sharma (2012:33) terms a global apartheid that “exists not only at the level of *keeping out* migrants but also at the level of their ‘differential inclusion’ as lawfully subordinated persons”. Particularly targeted are refugee claimants whose ‘unsavoury’, ‘dangerous’, and ‘spontaneous’ movements (Nyers 2003:1070) warrant responses of control in the form of visa requirements, third country agreements, and detention. Contradicting its image as a welcoming country that provides safe haven to those in need, Canada is no exception to such regulatory attempts. Over the past decade, the state has been attempting to curb the movements of refugee claimants, which is evident through visa requirements (Gilbert 2013; Villegas 2013a), the introduction of a Designated Country of Origin (DCO) category that subjects persons from certain countries to faster timelines and limited means of appeal (Huot et al. 2016), and the maintenance of the Safe Third Country Agreement (Wright 2018). These moves alert us to the securitization and criminalization of persons who are not criminals. As the title of this chapter asserts, it is not illegal to claim asylum, regardless of the means or modes by which a person makes a claim. As a result of the securitization of refugee claimants, this population is situated within an increasingly unusual position within the state—as having a problematic (yet legal and authorized) presence within the state. This dissertation analyzes this positioning of refugee claimants within the Canadian state.

The key question guiding this chapter is, how can we conceive of the abnormal positioning of refugee claimants? Acting as the conceptual outline of this dissertation, this chapter introduces irregularization and irregular status as key terms in which to analyze and comprehend the positioning of refugee claimants within the Canadian state. Drawing on critical migration scholarship, and the influential concepts of illegality and irregularity, I demonstrate how existing approaches based on these concepts limit how scholars come to terms with the experiences of precarious migrant and refugee populations. As a result, I argue there is a need for an expanded understanding of irregularization. This chapter highlights the importance of this expansion from one that is synonymous with illegalization and legal status to one that prioritizes subjectification and presence. As I detail below, I approach irregularization as an assemblage that works to target and question presence as abnormal, ‘out-of-place’, or otherwise irregular, which results in the status of irregularity, which reflects one’s problematic presence, restricts access to social resources, and affects life chances. This approach to irregularization speaks to the processes, practices, and experiences that shape the lives of precarious noncitizens, such as refugee claimants, by offering new insight on regulation within the Canadian asylum context and the power relations that define the daily lives of this population.

The chapter begins with a definition of irregularization and irregular status, which is then followed by a discussion of existing approaches to illegality and irregularity to demonstrate the relevance of my argument for a conceptual expansion. In order to more fully understand irregularization, specifically how it is produced, operates, and is experienced, I explore this concept in relation to borders, (non)citizenship, and humanitarianism which are key lenses that frame critical migration scholarship. I understand borders, (non)citizenship, and humanitarianism as implicated in the creation of identities and subject positions, the regulation of movement, and

the mediation of rights and entitlements, and as consistently subject to (re)negotiation. Briefly, borders emerge whenever and wherever selectivity and verification controls are found, which gives rise to categorizations and/or reduced pathways to rights; citizenship is an articulation of identity that emerges in relation to gradations of otherness and justifies the privileging of unequal rights; and humanitarianism identifies, classifies, and manages populations deemed to be in need of protection and assistance in ways that create hierarchies of legitimacy and deservingness. I situate these definitions of borders, (non)citizenship, and humanitarianism within my approach to irregularization to demonstrate how they irregularize refugee claimants and as result should be thought of as irregularizing assemblages. This conceptual framing of irregularization offers a contribution to the critical migration literature by shedding new light on the regulation of migration and precarious noncitizens. I conclude the chapter with a discussion of how irregularization/irregular status is challenged through what I term ‘acts of liberating irregularity’. Building on Isin’s (2002, 2008) concept of acts of citizenship and ideas of commoning (Anderson et al. 2012, 2009; Casas-Cortés et al. 2014a), acts of liberating irregularity offers an analysis of resistance within the Canadian context that not only complements calls for alternative approaches to contestation, but that also offers critical and nuanced insight on the politics of irregularization.

### **What Is Irregularization?**

In trying to come to terms with the constructions and experiences of refugee claimants, I draw from critical migration scholarship, which examines the practices and outcomes of power on the lives of migrant and refugee populations. Although much of this literature engages with the concepts of illegality (for example Coutin 2000; DeGenova 2002) or irregularity (for example

Hepworth 2014; Squire 2011), the issues and tensions that define my dissertation research cannot be adequately captured by these concepts as they are currently defined. As I discuss below, illegality and irregularity are limited in their focus on legal status, including undocumented migrants, which draws attention away from the importance of presence and subjectification processes, and their implications on the rights, rights claiming, and life chances of other migrant and refugee populations who are legally present within the state. I therefore argue for an expanded understanding of irregularity/irregularization to take into account the alternative ways in which migration regulation is practiced and experienced (see Hepworth 2014; Nyers 2011).

I define irregularization as an assemblage of heterogeneous elements (i.e. policies, practices, documents, actors, knowledges, encounters, etc.) that come together in unpredictable, inconsistent, and contradictory ways to problematize the presence of persons/groups as abnormal, ‘out of place’, or otherwise irregular (Hepworth 2014:4) and to regulate movement and access to services such as healthcare. As an assemblage, irregularization entails inconsistencies and contradictions and alludes to the nonlinearity of governance. For O’Connor and Ilcan (2001:1), assemblages “are forms of the coming-together or the encounter of different artifacts, things, bodies, movements, sights, and sounds” that “create events and the possibility of events”. For them (ibid.:3), “the notion of assemblage discloses a variety of possibilities that transform even the most ordinary place into a space of events”. Villegas (2015a), for example, utilizes the concept of assemblage to draw attention to how expanded realms of surveillance are produced within everyday places, such as banks and employment agencies, and how these increase the insecurity and vulnerability of Canada’s precarious status migrants. This concept captures well the messiness and importance of the everyday, and alerts us to the labour that goes into irregularization, being the relations between data, documents, policies, actors, encounters,

and knowledges that shape space, identities, and access to resources (see Villegas 2013a:2202). As Müller (2015:27) notes, the concept highlights how and why exercises of power emerge and operate, are (precariously) held together, shape space and action, and ‘fall apart’. In this regard, approaching irregularization as an assemblage lends to an analysis of ordinary everyday places, such as Toronto’s doctor’s offices, hospitals, and walk-in clinics, as worthy sites of analysis that consist of a variety of possibilities.

As I discuss in the section below, my approach to irregularization differs in the sense that I prioritize presence over (il)legality. Understood as ‘being here’, or one’s concrete locality within space, presence is intricately connected with rights, which means targeting and questioning presence interrupts rights and claims to them (Rygiel 2011a:13-14). A focus on the ‘hereness’ of persons/groups highlights their connections with and contributions to the community and their occupation and use of space which work as foundations to rights and rights claiming. For Rygiel (2011a:14), to deny and interrupt ‘presence’ means “hindering the visibility, association, recognition, status, and rights that come with being of the city”. In my research on refugee claimants in Toronto, who are legitimate authorized temporary residents of both the state and the city, their presence was problematized to justify restricted access to healthcare. Framed as ‘bogus’ and as threats to finite healthcare resources, the connections and contributions of refugee claimants to their communities—which for some resulted from their presence of over five years (Burke 2017)—was interrupted so as to (justifiably) regulate access to healthcare. Similarly, Hepworth (2014) alerts us to the important role of presence in the regulation of migrants. She analyzes how the presence of irregular Senegalese traders, undocumented Latin American caregivers, and Romanian Roma living in unauthorized camps—all of whom are “considered as ‘illegitimate outsiders’ in the nation”—are “ascribed different

degrees of legitimacy” that are “distinct from their actual legal status” (2), resulting in different experiences among these migrants within the Italian state. It is this targeting of presence, regardless of legal status, that interests me, and that shapes my approach to irregularization.

If irregularization is the problematization of presence, what emerges from this assemblage is the status of irregularity, which is not a juridical status, but a positioning, or an attribution of an identity, that reflects one’s constructed abnormality or problematic presence within space. Approaching status in this manner complements Turner’s (1989:2-5) definition of status as a ‘standing’ or ‘positioning’ that is based upon forms of evaluation and that is “hierarchically ranked in terms of greater or lesser privileges and prestige”. Furthermore, to view status as positioning relates to discussions of presence; as Isin (2002:25) argues, the creation and positioning of individuals, and the production of new forms of identity and belonging, require presence within space. As a positioning that emerges through assemblages, irregular status is constituted within everyday encounters and relations; it is contingently configured and enforced by state and non-state actors so as to limit access to social resources and to rights. I argue this construction and attribution of irregularity is reflective of a subjectification process because attempts to regulate occur through the identification of (irregular) subjects. Here, subjectification is defined as a form of power that marks and identifies individuals as subjects so as to incite possible actions (Foucault 1982:781). While scholars have alerted us to the construction of refugees as victim subjects (Fassin 2008) or resilient and entrepreneurial subjects (Iltan and Rygiel 2015), I draw attention to an additional subject who emerges through regulation, which is the irregular subject.

To approach irregularity as ‘status’, rather than ‘condition’ (Hepworth 2014; Squire 2011) offers unique insight on this concept. I argue that condition alludes to notions of outcome,



way of being, or state of affairs which conjure images of fixity. This is noted in the use of condition to describe the juridical status created through irregularization/illegalization. Status, on the other hand, alerts us to the processes that position persons/groups within hierarchies in ways that attribute identities; it attends to the ways persons are (re)shaped/(re)fashioned in space that exceed the focus on law and policy. In this regard, irregular status speaks to the many subjectivities that are constructed through migration regulation. Considering the importance of illegality and irregularity (as currently defined in the literature) in my analysis of irregularization, I offer below an overview of these concepts and their specific limitations in relation to my research project.

#### Existing Approaches to Illegality and Irregularity: Strengths and Weaknesses

Produced through processes of illegalization<sup>7</sup>, migrant illegality is defined as “a juridical status that entails a social relation to the state”, “a pre-eminently political identity” (DeGenova 2002:422) and a “spatialized condition” that reproduces borders within everyday life (439). Illegality draws attention to how the segregation and oppression of migrant groups occurs via legal frameworks. This is achieved through a focus on how state laws, bureaucracies, and border technologies construct and constitute illegality. Illegal migrants are vulnerable to deportation or deportability<sup>8</sup> (DeGenova 2002; Fassin 2011), forms of confinement, and ambiguity<sup>9</sup> (Coutin 2010:201). For Nyers (2010:135), illegality “is meant to undermine the moral character of

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<sup>7</sup> DeGenova (2002:429) defines illegalization as “the legal production of migrant ‘illegality’”.

<sup>8</sup> For DeGenova (2002:439), “migrant ‘illegality’ is lived through a palpable sense of deportability”, defined as “the possibility of deportation”.

<sup>9</sup> According to Coutin (2010:201), ambiguity can be understood spatially, in that migrants are situated outside of a nation-state even though they are physically present. She also claims that ambiguity is continual, whereby lives may be normal and abnormal at same time (207).

certain types of migrants” by “impl[ying] a breaking of the legal order, a violation of rule-following norms of behaviour, and an intention to commit a wrong”. This imposition of illegality is evident in descriptions of refugee claimants crossing the US-Canada border (Curry 2017; Harris 2017; Lagerquist 2017) and particularly in discussions of Mexican nationals (Villegas 2013a). For Scheel and Squire (2014:192), emphasizing the legal/illegal binary over the forced/voluntary binary undermines refugee protection, reduces asylum spaces, and the rights of persons seeking protection and safety.

This latter point on the rights of persons is evident in the emergence of ‘spaces of nonexistence’ (Coutin 2000). These spaces, which are located within the state, are characterized by “forced invisibility, exclusion, subjugation, and repression” (DeGenova 2002:427; see Coutin 2000:30). For Coutin (2000:28-29), nonexistence is derived from the contrasting combination “between physical and legal presence” of ‘illegal’ migrants that renders them ‘legally absent’. Although spaces of nonexistence are imagined, their material effects include hunger, unemployment, and death (ibid:29). In Canada, failed refugee claimants have died (Javed 2011) because, according to ex-Minister of Immigration Jason Kenney, there is “no legal, moral, or political obligation to give taxpayer services to [...] people who are effectively illegal migrants” (Jones 2013). Illegality effectively attends to the role of state and global actors in migration regulation, and to the everydayness of illegality. However, there are limitations with this approach. Although illegality is foundational to critical migration scholarship, the attention to legal status, the state border, and border agents draws attention away from other actors and factors that may be employed to control mobility, such as mundane and quiet practices within the everyday. In this light, an alternative and potentially more useful concept in critical migration scholarship is irregularity.

Irregularity is an attempt to describe the movement of people across borders or the presence of people within a location without having to rely on the state-centric perspective of illegality that may criminalize migrants and delegitimize migrant strategies and agency (Squire 2011:3-4). Irregularity focuses on state structures that generate experiences of instability, temporariness, insecurity, and exclusion, as well as the decisions of migrants themselves who resist state structures and categories (Johnson 2014:123). However, like illegality, irregularity is defined as crossing state borders or remaining within a state without permission (Bloch and Chimienti 2011; McNevin 2006; Squire 2011). For example, Johnson (2013:78) defines irregularity as “cross[ing] a border without permission, or in a way that is outside of the provided frameworks”; for her, “all mobility not strictly regulated by the state is understood as ‘irregular’ or ‘illegal’”. Here, Johnson synonymizes irregularity with illegality, reflecting the original intention of this term as an alternative to illegality. In other words, the focus on illegality continues but through a different term.

However, some other scholars are attempting to expand the concept in ways beyond legal status. For example, Nyers (2011b) employs the concept to analyze how citizens are irregularized as a result of their status being rendered ‘inoperable’, while Hepworth (2014:4-7) approaches irregularity as heterogeneously experience and produced as a result of its constitution by legislations, discourses, and encounters that question and/or render presence illegitimate. I find her focus on presence to be particularly interesting and innovative. She describes how the presence of traders, care workers, and Roma are “ascribed different degrees of legitimacy, as distinct from their actual legal status” (ibid:2). For example, while the Roma are legitimate European citizens, their excessive mobility is used to delegitimize their presence within the state (ibid:3). Hepworth’s research alludes to how irregularization can exceed legal boundaries to

include presence, in addition to social imaginations and constructions. However, she limits her analysis by maintaining a connection with authorization/legality.

I respect the attention placed in the illegality literature on the state and the everyday, and I appreciate the shift towards presence and the attention on agency within the irregularity literature. However, both concepts are self-limiting in that they are unable to consider how exercises of power shape the lives of those persons who are legal residents of the state, such as refugee claimants. As a result, I build on this literature by calling for an expansion of irregularization and irregularity. This expanded approach complements the literature by drawing attention to the implications of exercises of power on life chances, the heterogeneity of experiences, and how irregularity is produced and by what means (Squire 2011:7). However, it nullifies the barrier of legal status by focusing on presence and the status of irregularity. Below, I develop this concept alongside those migration literatures that engage with borders, (non)citizenship, and humanitarianism in order to offer a more a detailed discussion and analysis.

### The irregularizing assemblages of borders, citizenship, and humanitarianism

Bordering, citizenship, and humanitarianism are key concepts of critical migration studies. As regulatory assemblages, bordering, citizenship, and humanitarianism consist of various elements that create legitimate and illegitimate, normal and abnormal, statuses and presences which inform rights and entitlements, and shape the daily experiences of refugees. Scholars are demonstrating the importance of these concepts in diverse ways. For example, regarding borders, Gorman (2017) analyzes how the refugee category constructs Central American asylum seekers as illegally present in the United States and subject to deportation and detention; for her, legal definitions are representative of bordering to delineate refugee categories. Landolt and Goldring

(2015) draw attention to the precariousness of (non)citizenship within Canada, and how this alters rights and entitlements (see Goldring and Landolt 2013), while McKay et al. (2011) highlight how Australia's Humanitarian Programme constructs asylum seekers as incorrectly and illegally seeking access to humanitarian protection, and therefore as undeserving of protection. Ticktin (2006:44) demonstrates the connection between borders, citizenship, and humanitarianism through France's humanitarian 'illness clause'; it polices the mobility of undocumented migrants by choosing exceptional subjects over others and creating 'diseased citizens' who are "liberated from suffering" but "not liberated into full citizenship". Combined, the above research highlights the importance of borders, (non)citizenship, and humanitarianism within critical migration scholarship, and the intricate relations between them.

Scholars also highlight how migrants are subjectified through borders, citizenship, and humanitarianism. Perhaps the most well-known example is the notion of 'refugeeness' which defines the helpless refugee subject (Malkki 1995). Rygiel (2011:2) discusses how the subjectivity of a person can range from citizen, to quasi-citizen, noncitizen, or abject subject within detention sites, while Mezzadra and Neilson (2012) speak of the numerous subjectivities that come into being through the border. Ilcan (2013) and Ilcan and Rygiel (2015) approach humanitarianism as subjectifying individuals through categories, such as the responsible or entrepreneurial refugee. Finally, Squire (2011:14) defines irregularity as "produced through various processes of (ab)normalization and subjectification that are practiced across diffuse sites by heterogeneous means". To view irregular status as a type of subjectification process, which, as I argue below, emerges through borders, (non)citizenship, and humanitarianism complements migration scholarship. By drawing on all three, irregularization is presented in a more comprehensive manner. This is offered in detail below.

Within critical migration scholarship, scholars engage a great deal with borders to draw attention to how, where, and in what ways selectivity and verification controls emerge to give rise to categorizations and reduced rights. While the prominence of border research leads Walters (2015:1) to question the “rather automatic way in which questions of migration and borders have become woven together”, I argue borders offer important insights into (the performance of) state sovereignty and the relationship between power and space. Rather than simply territorial locations, borders are emergent, contingent, polysemic, strategic, and embodied political and politicized “processes, practices, discourses, symbols, institutions or networks through which power works” within and beyond the state (Johnson and Jones 2011:62). They are “enacted, materialized, and *performed* in a variety of ways” (ibid.) to facilitate or curtail movement (DeGenova 2002; Rumford 2012), and hierarchically categorize people in ways that correspond with differential mobility rights. Scholars analyze the border through: biometric passports and data monitoring (Amoore 2006); raids (Inda 2011); airports (Mountz 2010); islands (Mountz 2017); state agents (DeGenova 2002) and everyday actors (Rumford 2012). Although the idea of what and where the border is continues to be debated and illuminated, ideas regarding the underlying effect of the border remains the same: border construct or “mark some bodies as legitimate and others as out of place” (Johnson and Jones 2011:61). This construction of persons is not binary but multiple. As Mezzadra and Neilson (2012:62) argue, borders are involved in the “proliferation of subject positions that are neither fully included nor fully excluded” and “subjectivities that are neither fully insiders nor fully outsiders”. My research sheds light on the construction of border statuses through the concept of irregularization. To do this, I focus on the everyday sites (borderzones) and performances (borderwork) of borders.

Borderzones are sites of homogenization and standardization that monitor and regulate populations in strategic everyday sites through mundane activities. Within these sites, any action or person that does not reflect the established norm (asserted through mundane activities) is deemed abnormal (i.e. irregular) and subjected to restricted rights and access (Isin and Rygiel 2008; Monforte 2016; Walters 2011b). Here, borders work through the information offered by documents and data which are then interpreted, evaluated, and compared against established standards/norms, and used to produce knowledge about the person attached to documents/data. For Bigo (2011), what emerges through these interpretations are forms of dataveillance (i.e. statistics) that regulate mobility through one's data double. While Inda (2011:83) argues the workplace can be thought of as a borderzone where mobile populations are policed through raids, I argue that healthcare centres can also be thought of as borderzones, where standardized documents and procedures work to irregularize the presence of refugee claimants with IFHP coverage and produce irregular statuses.

Borderwork adds an important and complementary addition to borderzones by focusing on the role of everyday actors in the construction or erasure of borders (Rumford 2012:897). As Rumford (2008:3) argues, constructing and contesting borders (i.e. borderwork) is "very much the business of citizens, of ordinary people"; they are involved in facilitating or restricting mobility, creating zones that determine acceptable types of activities, and contesting and undermining "borders imposed on others". Through this concept, I demonstrate the important role of everyday healthcare professionals in the enactment of the border and the construction of irregularity. Borderwork is not limited to a particular spatial scale, meaning that it can range from the geopolitical to the local (Rumford 2008:3). For example, the work of Médecins Sans Frontières (MSF) can be conceived of as humanitarian borderwork, whereby in their attempts to

alleviate the violence of the border in the Mediterranean, the MSF is also implicated with the governance of mobility by introducing and consolidating new hierarchies and categories of life (Pallister-Wilkins 2017:6). Borderzones and borderwork alert us to the border assemblage, which entails data, documentation, everyday encounters, and various actors and sites. I argue this assemblage can be conceived of as an irregularizing one. I draw from and contribute to scholarly discussions of borders through a much-needed focus on the Canadian asylum context (see Mountz 2010; Villegas 2015a).

The border is directly implicated in the production of ‘other’ or noncitizen subjects, therefore, I also engage with (non)citizenship in my analysis of irregularization, since “the regulation of mobility plays a key role in articulations of citizenship and who can and cannot be a citizen” (Nyers and Rygiel 2012:3). Rygiel (2010:11-14) alerts us to the importance of citizenship within critical analyses of migration. For her, citizenship is becoming a globalizing regime of “technologies, policies, practices, and discourses” utilized by governing bodies to regulate mobile populations, particularly those moving from the Global South to the Global North, and their ability to access rights. This important contribution to citizenship scholarship is founded on the work of Isin (2002,2008).

Isin (2002:ix, 2) defines citizenship as an identity within space (city or state) that is articulated and emerges in relation to others (being strangers, outsiders, and aliens); it shapes conduct within space, and is constituted by various strategies and technologies (such as marginalization, enrolment, and rites) that legitimize its inheritance and exclusivity. In this regard, citizens are constructed as different from “strangers, outsiders, and aliens who they construct as their alterity” (ibid:36). In other words, a dialectical approach to citizenship focuses on the emergence of otherness (i.e. noncitizenship) in relation to citizenship. Otherness is formed



through encounters, and as groups begin to realize themselves in these encounters, they invent technologies that “alter configurations and properties of space so as to fragment, weaken, destabilize, constrain, immobilize, segregate, incarcerate, or disperse other groups as much as possible while increasing their own solidarities” (ibid:49). For example, Villegas (2015b:2359) analyzes the encounter between entrants and border authorities as involving moments of interrogation, intimidation and humiliation so as to legitimize practices that constrain movement and construct the identity of stranger. For Hepworth (2014:2), encounters demonstrate how citizenship is “modulated in the everyday to constitute a range of legitimately and illegitimately present non-citizen subjects”. Bhuyan (2012) offers important insight on how the encounter modifies noncitizenship through her analysis of Toronto’s violence against women shelters. These scholars highlight how encounters are important vehicles in which to analyze presence, especially in relation to citizenship and irregularization; one’s presence within space forces encounters with others. It is here that bodies are deemed in or out of place and recognized as ‘other’ or irregular. To be determined as illegitimately present (re)constitutes the person as a noncitizen or as not belonging, sometimes regardless of legal status (Hepworth 2014). I understand such (re)constitutions of the person as reflecting irregular status.

In the Canadian context, much attention is placed on precarious status noncitizenship, being the legal statuses that are constructed through migration policies and legislation; again these are not binary statuses but rather gradations of “authorized and unauthorized forms of non-citizenship” (Landolt and Goldring 2013:3). Precarious noncitizenship lacks “elements normally associated with permanent residence (and citizenship)” (ibid:14) and is characterized by vulnerability, insecurity, and inequality. The precariousness of noncitizenship emerges through encounters between service providers and noncitizens through what Landolt and Goldring

(2013:15) term ‘conditionality work’, being the ability of everyday actors to uphold (or challenge) state-imposed conditions. In this light, their work complements Isin’s (2002) emphasis on the encounter and Rumford’s (2006) concept of borderwork. Scholars have shed critical light on the implications of precarious noncitizenship in Canada with regards to housing (Kisoon 2013), employment (Jackson and Bauder 2013; Landolt and Goldring 2013), women’s shelters (Bhuyan 2012), healthcare (Villegas 2013b) and education (Villegas 2013c; Young 2013). I intend to contribute to this research by drawing attention to how precarious noncitizenship is constitutive of irregularity, in that legal status is very much a factor in evaluations of (ab)normality. Drawing from Isin (2002, 2008) and other critical citizenship scholarship (Johnson 2012; Landolt and Goldring 2013; Sharma 2001), I consider how refugee claimants are constructed as ‘other’—a term that speaks to irregular status—via an assemblage of heterogeneous elements that constitute (non)citizenship within the everyday. By approaching (non)citizenship as an irregularizing assemblage, attention is directed to how irregularity is articulated within space in ways that, as Hepworth (2014:7) argues, occur “each time particular bodies are deemed in- or out-of-place”; it is this problematization of presence that is constitutive of irregularity. Establishing a connection between (non)citizenship and irregularization speaks to McNevin’s (2011:15-16) argument that the production of abnormality is part of the history of citizenship.

Lastly, in order to understand irregularization, it is important to engage with humanitarianism. Like borders and citizenship, humanitarianism is directly implicated in the regulation of refugee populations (Ilcan 2013; Ticktin 2006; Walters 2010) and in the construction of the helpless refugee subject (Malkki 1996:388). Humanitarianism is most commonly understood as an assemblage of actors, practices, and rationalities that aim to improve

the conditions of those who are suffering in times of crisis and emergency, such as through the provision of food aid, temporary shelter, or medical care. However, this affiliation with welfare tends to justify practices, actions, and frameworks that may reduce the rights of refugees (Chimni 2000) through the implementation of dysfunctional, ineffective, and counterproductive solutions (Belloni 2007:454). For example, Ilcan et al. (2017) highlight how the humanitarian practice of self-reliance in Uganda's Nakivale refugee settlement offers a decontextualized managerial solution that effectively shapes refugee camps in ways that violate the rights of refugees and maintains marginalization and precariousness. These outcomes are a result of the construction of the refugee as a dehistoricized and depoliticized "pure victim" which strips refugees of "the authority to give credible narrative evidence or testimony about their own condition" (Malkki 1996:378). The voicelessness of the refugee victim requires experts who analyze emergencies and suffering, and determine what types of assistance and protection are required. In this light, humanitarianism is imbued with difference, reflecting Ticktin's (2011b:261) argument that the refugee victim produces and maintains unequal power relations between "those who have the power to protect, and those who need protection—those who suffer, and those who recognise and address suffering". If indeed humanitarianism is an assemblage that approaches refugees as "object[s] of knowledge, assistance, and management" (Malkki 1996:377) then I argue that it should be conceived of as an irregularizing assemblage which accords irregular positionings or statuses so as to regulate refugee populations, specifically, refugee claimants.

Refugee claimants are those persons who have yet to gain full access to the humanitarian system because of their need to prove their suffering; however, by making a refugee claim they are included, although to a minor extent. It is this label of refugee 'claimant' that distinguishes their 'to be determined' position. For Zetter (1999:2,8, cited in Chimni 2000:254) such labels

“narrow down and restrict the allocation of the most privileged label—refugee”, highlighting how labelling operates “as instruments of control, restrictionism and disengagement”. In Canada, labels different refugee populations, such as Designated Foreign National, Designated Country of Origin, inland claimant, port-of-entry claimant, rejected claimant under (or not under) deferral of removal, and protected person. These labels not only work to regulate the rights of refugees, but also create “certain assumptions and expectations about humanitarian treatment and responses” (Zetter 1999:8, cited in Chimni 2000:254). It can also be argued that these assumptions work to shape how the characteristics of this population are imagined; as Isin (2002:34) states, the construction or recognition of ‘other’ includes attached negative meanings, images, and characteristics. This dissertation highlights how the label of refugee claimant conjures negative stereotypes which are used to justify restricted access to resources and services such as healthcare. It also illustrates how the irregularity of refugee claimants is a result of their positioning within the humanitarian system—as being within yet outside of it. This ambiguity is an important element in the irregularization of refugee claimants, and in the justification of limited humanitarian responses.

Seeking to attain humanitarian protection on one’s own volition (rather than waiting to be chosen and relocated by governing bodies) deems refugee claimants to be ‘rule breakers’ or ‘queue jumpers’ who move outside of regulated pathways and who are less deserving of humanitarian protection. For example, Gilbert (2013) speaks to how the arrival of an estimated 300 Mexican refugee claimants to Windsor, Ontario was portrayed as a crisis for both the local economy and the Canadian immigration system; the large numbers of refugee claimants resulted in a restrictive visa program for Mexican nationals to curb movement and reduce spaces of asylum (see Villegas 2013a). The Roma have also been targeted in similar ways (Diop 2014;

Levine-Rasky 2017). In other countries such as Israel refugee claimants are similarly constructed as security and economic threats, which justifies a ‘hands off’ approach to assistance and their overall well-being (Duman 2015). I understand the difference of refugee claimants as reflecting their irregularized status. As I demonstrate in chapter 5, female refugee claimants are particularly vulnerable to irregularity; their claims of gender-based violence do not ‘fit’ the definition of ‘refugee’ (Bhuyan et al. 2016a:421; Dauvergne and Millbank 2010; See 2016) resulting in the denial of rights and protection and a specific gendered experience of irregularity. This is an important point to consider since Canada has seen a steady increase in the number of women making refugee claims over the past decade (Government of Canada 2013a). Establishing a connection between humanitarianism and irregularization highlights the inconsistencies and effects of humanitarianism on refugee claimants in Canada, particularly women.

### **Resisting Irregularization**

Approaching irregularity as status provides the space to consider resistance and struggle, because it is the constitution of the subject via subjectification that brings about agency (Fassin 2008:534). The constitution of a subject is not fixed, but rather is subject to change, reworking, and resistance, resulting in a political subjectivity. Additionally, approaching irregularization as an assemblage allows for considerations of the frictions, failures, and unintended effects that produce contestation (see Ilcan 2013). In this light, if irregularization entails the regulation of persons/groups via presence, then presence is also utilized in a manner to challenge regulation and enact the self as a political subject.

In addition to regulation, presence also represents an important lens in which to analyze resistance. Varsanyi (2008:39), for example, speaks of how presence indicates migrants as

“inhabitants” and as having a stand “from which to lay claim to membership”. Here, presence asserts one’s connection with and contribution to the community. Coutin (1999:60) makes a similar argument, in that the assertion of presence represents a claim of “both legitimacy and formal membership in the polity”. For DeGenova (2010:103), presence represents a “definitive social and political ‘objective’ fact”—an “audacious affirmation”. In Canada, presence has worked to regularize the status of nonstatus persons (Nyers 2010), and assist in the development of Sanctuary Cities, highlighting how the assertion of presence can afford rights and recognition<sup>10</sup>. In my research, presence was utilized in a similar way. However, this assertion of presence differed in one important manner: it was achieved in much less visible and familiar ways than currently discussed in the literature (DeGenova 2009; Johnson 2015; Rygiel 2011). While I understand, for example, the national day of protest as a visible proclamation and assertion of presence, and the community health centre as a visible spatial manifestation that recognizes the presence of refugee claimants (see chapters 3 and 4), other less visible ways that also drew on presence include word of mouth and system navigation work (see chapter 3).

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<sup>10</sup> The presence I am analyzing is a specific one that is set within a specific context and by a specific category of precarious status noncitizens. Specifically, this is a focus on the presence of refugee claimants in the Canadian context, persons who are legitimately present within the state but whose presence is problematized as a result of relations and encounters in the everyday. However, it is important to position presence in relation to those who are not or cannot be present, specifically, those migrants who have lost their lives along/within border spaces. For Délano Alonso and Neinass (2016) there is a lack of care for, and visibility of, migrant bodies noted in mass unidentified burial sites, and a denied presence by situating these sites far from the public eye with little option for identification. However, they also alert us to how the non-presence of migrants is rendered present by activists, allies, and migrant rights organizations who work to politicize the bodies of the dead. In this regard, “these bodies became an acknowledged presence [...] only at their moment of death” (ibid:425). As Kovras and Robins (2016:43) argue, the “migrant body can be political”; its existence and presence is “a product of politics”, including “the corpse itself as a political subject”, which illustrates “the social and political processes around death” and the affective impacts that “give them power over the living”.

Through presence, refugee claimants and allies challenge the state's prerogative to differentiate and discriminate against refugee populations, at least in the context of healthcare as I illustrate in this dissertation. In this regard, my research demonstrates that there are many ways of claiming and asserting presence. Through these assertions we see the emergence of a new political subject.

If problematizing the presence of refugee claimants facilitates the creation of an identity that I understand to be irregularity, then asserting presence (i.e. the right to be present and to have rights associated with presence) means that the irregular subject is constituted in a manner different than originally accorded to them. As Foucault (1982:331) notes, much resistance revolves around the contestation and refusal of certain forms of subjectification<sup>11</sup>, and here we have resistance of irregular status, an identity that reflects one's problematized presence in space. Many scholars have noted the importance of presence in this regard. DeGenova (2010:110) argues presence is a proclamation of existence – a 'politics of anti-identity' (see Johnson 2015:960). McNevin (2011) and Nyers (2010) demonstrate how claiming presence enacts precarious status noncitizens as agents who create beginnings and produce new notions of political belonging. Rygiel (2012:816) discusses the importance of presence within the context of detention centres, where migrants, refugees and allies "reinvigorate presence" to destabilize thresholds of belonging and citizenship, such as through the creation of "new cartographies of camp spaces". Additionally, Johnson (2015:958) alerts us to how the assertion of presence via refugee protest camps creates a political subject that is 'in addition to' the citizen. Here, presence—being "an assertion of occupation of space"—is about staying and situatedness, which

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<sup>11</sup> For Butler (1997:2, cited in Fassin 2008:534) subjectification "consists precisely in this fundamental dependency on a discourse we never chose but that, paradoxically, initiates and sustains our agency" and "signifies the process of becoming subordinated by power as well as the process of becoming a subject".

are utilized “as resources for enacting political subjectivity”; this is a subjectivity that emerges “on the basis of being located, present, and *here*” (ibid:959-960). Building on Lefebvre’s (1996) work on ‘right to the city’, Rygiel (2011:13) argues that presence, which entails “the use, manipulation, struggle, and contestation over space”, is essential in enacting oneself as a political subject (regardless of migration/legal status) and in challenging thinking around rights. As I define below, I analyze the assertion of presence through the concept of acts of liberating irregularity, which I approach as reminiscent of commoning, being the realization of political, social, and economic rights of commoners through a denial of exploitative relationships, and the acknowledgement of the entitlements of all persons to not be excluded or distinguished from others (Anderson et al. 2012:85). In an attempt to come to terms with the political subject that emerges from these acts, I build on this definition of commoning to argue the political subject is the ‘common’ subject who is a claimant of justice and rights.

I approach commoning as the opening up and/or re-appropriation of enclosed spaces so as to challenge discrimination and differentiation. It is similar to presence, which also emphasizes the occupation/use of space to claim rights hence the usefulness of commoning in my research. Drawing upon the work of Federici (2010) and Harvey (2012), Casas-Cortés et al. (2014a:455-457) discuss commoning as a verb that consists of: social relations founded upon cooperation and responsibility; a refusal to accept the suffering of self and others; a refusal to differentiate and separate ourselves from others; and “the production of ourselves as a common subject”. In asserting presence, or one’s occupation of space, (or the right to it), we have the emergence of a ‘common’ political subject or the constitution of self as commoner, who creates a difference by challenging injustice, differentiation, and the enclosures that constitute irregularization. In this light, irregularization can also be situated in discussions of both



regulation and resistance as a result of the possibility for the emergence of new political subjects.

For example, consider the following statement from a refugee claimant on the issue of the IFHP:

What I want to say is that, I don't think that's a realistic decision to make [to take away healthcare] because, [...] whether I am a refugee claimant or not, I am in your country. At the end of the day, if I fall sick and die, who's responsible? It's not my responsibility because I am in your hands. I was given into your hands. I came here as a refugee. You took me as a refugee (Interview with Refugee Claimant, Toronto, 18 October 2015).

This quote sheds light on how we can conceive of the assertion of presence and the common subject. For this refugee claimant, their presence is not only based upon an idea of legitimacy because the country “took” them as a refugee, but also responsibility, in that their presence makes the state responsible for their wellbeing. In other words, this refugee claimant challenges the state's sovereignty to define difference by declaring it as responsible for sharing its resources with those who are present, such as refugee claimants. My emphasis on presence in relation to resistance complements the work of other scholars such as Johnson (2015) who analyzes ‘re-taking presence’ in the context of refugee protest camps in Vienna and Berlin, and Squire and Darling (2013:62) who define ‘rightful presence’ as emerging out of “everyday encounters that potentially question statist distinctions such as [...] ‘citizen’ and ‘noncitizen’”. As noted above, I analyze such challenges through the concept of acts of liberating irregularity.

Acts of liberating irregularity are deeds or conducts that aim to free oneself or others from irregularization or irregularity, through visible and less visible forms of struggle and resistance. These acts are constituted by claims that assert a right to be free from discrimination and irregularity produced through irregularization. Specifically, it entails a claim of being present and the right to be present and therefore a right to have the rights affiliated with presence within space. In this dissertation I highlight acts of liberating irregularity as: the continued provision of healthcare; as a provincial policy; and as system navigation work, among others. Although all

three examples are completely different from the other, they are all founded on the underlying attempt to challenge irregularization/irregularity.

My understanding of acts of liberating irregularity is based upon the concept of ‘acts’, being those deeds that “instantiate ways of being political” and that produce ruptures or breaks in “given orders, practices, and habitus” (Isin 2008:36). They represent a shift in focus away from actors to instead “constitutive moments, performances, enactments and events when a new identity [...] is brought into existence”, and to “instances when something, however small and seemingly marginal, is changed, possibly for the first time” (Walters 2008:192). Acts provides the space to focus on the importance of ‘moments’ and ‘performances’ of solidarity and those seemingly minor events that challenge assumptions, constructed identities, and the givenness of established ways of being. In this regard, acts is fitting in the case of the IFHP since they were momentous and momentary, altered perceptions of healthcare rights through protests, policy change or the creation of networks, and brought into existence new political identities. To establish a connection between ‘commoning’ and acts of liberating irregularity highlights their similar foundations as ‘doings’ which rupture arbitrary foundations of injustice. Acts of liberating irregularity challenge the inequality and discrimination that is produced through irregularization through acts that both make a difference and enact political subjectivities (i.e. common subjects). Here, performativity and solidarity work to redefine the relationship between status, rights, and subjectivity.

My approach to acts of liberating irregularity is based upon the influential concept of acts of citizenship (Isin 2002, 2008), being those ‘breaks’ or ‘ruptures’ established within a given order through a “capacity to think and act differently”, specifically to think and act as a citizen regardless of legal status (Isin 2011:230). According to Isin and Neilson (2008:2), acts of

citizenship are “those acts when, regardless of status and substance, subjects constitute themselves as citizens or, better still, as those to whom the right to have rights is due”. This concept moves beyond state centric views of citizenship as status towards one of performance that is also constituted by struggle; these struggles in turn transform citizenship (Isin 2002:33). The usefulness of this concept is noted by Rygiel (2011b:6-7) who states acts of citizenship “invok[e] agency with respect to subjects who are frequently depicted [...] as being something other than political beings” and alert us to how “migrants assert themselves as *political subjects* by making claims against certain perceived injustices and inequalities”. However, emerging critiques are being launched at acts of citizenship, which have shaped my conceptualization of acts of liberating irregularity.

Scholars are beginning to note how acts of citizenship can veil over ‘momentary’ (Johnson 2012) or ‘unfamiliar’ acts, such as, for example, when migrant youth employ vernacular music and language to challenge standardized national language and to de-identify with the French nation-state (Ní Murchú 2016). For Müller (2016:63), existing approaches to acts may potentially romanticize politics of resistance at the expense of neglecting how the nation-state ultimately “determine[s] not only the debate but also the actual realization of concrete rights”. Johnson (2012:123) makes a compelling case for the importance of ‘moments’; while they do not overtly challenge systemic practices, they can establish noncitizens as rights bearing subjects and potentially create progressive change in their everyday lives. For example, she illustrates the moment when ‘illegal’ migrant children filed complaints about their living conditions with local Spanish authorities, demonstrating how and when the children established themselves as rights bearing subjects (ibid:115). Other scholars are concerned with the continued use of the term citizenship in analyzing the resistance of noncitizens. For Tonkiss and Bloom

(2015:840), “the theorization of justice and rights affecting noncitizens is only thought about in relation to the conceptualization of citizenship and *its* relationship with justice and rights”. They argue as a result, scholars are less able to develop a comprehensive understanding of justice and rights and the “real world issues that noncitizens face” (ibid:841). Similarly, Johnson (2015:957) notes how rights-claiming is more than an appeal to citizenship; for her, “to apply the framework of citizenship to noncitizen action risks missing key elements of the politics that are being articulated within noncitizen protest and engagement”. Others also question whether citizenship may erase other ways of being political or may reinforce the exclusionary identity and practice of citizenship by representing claims as appeals to and for citizenship (Papadopoulos and Tsianos 2013; Tambakaki 2015). These scholars are arguing for analyses of resistance that exceed the ‘citizenship’ barrier<sup>12</sup>. Such alternative conceptual approaches are possible. For example, consider: acts of social justice, which call attention to injustice and demand rights and recognition (Ilcan 2013); acts of demonstration that make visible unjust social relations (Walters 2008); and migrant counter-conducts that contest migrant criminalization and represent a ‘political becoming’ (Inda 2011). Within these calls to exceed citizenship, is argument to pay attention to less visible types of resistance.

Less visible or “less spectacular” types of resistance “emerge out of everyday practices” and operate in ways that ‘elude the gaze’ of “the order and borders of nation-states”, “while calling into question the status quo” (Ataç et al. 2015:6-7). Focusing on less visible and momentary forms of struggle and resistance keeps in mind not only everyday acts but also everyday effects of regulation through borders, citizenship, and humanitarianism that make

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<sup>12</sup> Whether one adheres to the concept of citizenship or not, the overall goal remains the same: to challenge conventional ways of identifying citizen and noncitizen subjects through fixed and constituted identities based on legal status, and alert us to who counts as a political subject.

momentous and visible resistances risky. For example, Nyers (2003:1086-1087) alerts us to ‘sovereign retakings’ or the reassertion of sovereign power in light of resistance. Through this concept, Anderson (2010:67-69) analyzes how migrant rights organizations waged a successful campaign to change the migrant status of domestic workers in England, which was then “re-taken by the state” through individualist and overly complex ‘special exercises’ that were not easy to legally challenge. Similarly, in my research, a refugee claimant shared their experiences of seeking out healthcare in the media, only to have their information publicly shared by Immigration Minister Jason Kenney (Interview with Doctor, Toronto, 20 October 2015); through their use of voice, this person was subject to a ‘sovereign retaking’ that rendered their privacy and security at risk. It is this light that Johnson’s (2012:123) argument rings evermore true: she reminds us that “even if we are able to understand action and voice on behalf of non-citizens and migrants as political, their subject positions within larger societal frameworks are vulnerable”. In my approach to acts of liberating irregularity, I emphasize political subjectivity alongside an awareness of the persistence and realities of power. In this sense, my intention is not to subjectify refugee claimants as transformative actors. Rather, I attend to how persons who are implicated in Canada’s refugee system, including citizen allies, constitute themselves as political subjects in various and not necessarily apparent or transformative ways. By focusing on both refugee claimants and allies, and visible and less visible acts, acts of liberating irregularity complements Nyers’ (2011:8) argument that the political subject can come from both “usual and unusual subjects, expected and unexpected voices, and obvious and not so obvious places, spaces, and temporalities”.

In light of the above, I argue that while it is important to maintain a focus that privileges noncitizen agency, I question whether citizenship, via acts of citizenship, is the most appropriate

framework to analyze migrant struggles due its conceptual barriers that may conceal other ways of being political, such as those that define my dissertation research. I also question whether this lens keeps in mind the actually existing realities of migrants and refugees who are denied the ability to claim rights due to a lack of knowledge on legal frameworks, entitlements, oppression, communication skills, a lack of broader support (Basok 2004:48,50), or simply a fear of state retribution. As a result, I argue for an approach to resistance that complements acts of citizenship, and the concerns that surround it. Acts of liberating irregularity offers such a solution. Through this concept, I am able to attend to the important moments that make a difference in the lives of refugee claimants through performativity and solidarity.

## **Conclusion**

In this chapter, I have offered a conceptual overview of my approach to irregularization. Drawing from the currently popular terms of illegality and irregularity, I detailed their strengths and limitations particularly with regards to my dissertation research. By doing this, I set a foundation in which to build from and expand upon these terms through my understanding of irregularization as assemblage and irregularity as status; these expanded approaches focus on the constructed abnormality (i.e. irregularity) of presence. Influenced by critical migration scholarship, I build upon this expanded approach to irregularization/irregularity through the concepts of borders, (non)citizenship, and humanitarianism, all of which offer important insight on power and regulation in the migration context. This offers insight into how we can conceive of borders, citizenship, and humanitarianism as irregularizing assemblages. My approach to irregularization/irregularity illuminates how experiences and productions of irregularity are inconsistent, unpredictable, and contradictory but nevertheless fraught with struggle. I analyze

this struggle through the concept of acts of liberating irregularity, which draws attention to both momentous and quotidian challenges to irregularization. It is this politics of irregularization that this dissertation analyzes.

The following three chapters offer an empirical analysis of the IFHP, each of which are dedicated to borders (chapter 3), (non)citizenship (chapter 4), and humanitarianism (chapter 5) to provide a more in-depth understanding of how irregularization is produced, experienced, and challenged within the everyday. Next, I engage with borders in my empirical analysis of the IFHP within Toronto's everyday healthcare places.

## Chapter 3<sup>13</sup>

### **The Irregularizing Assemblage of Bordering: Borderzones, Borderwork, and Acts of Liberating Irregularity**

Between 2012 and 2016, an untold number of refugee claimants—persons who have fled their country and made an asylum claim in another country—in Canada faced denials and restrictions to healthcare coverage as a result of amendments made to the Interim Federal Health Program (IFHP), a health insurance program provided to refugee populations. Implemented by the Conservative Party under the leadership of Stephen Harper, these amendments aimed to ‘defend the integrity’ and deter the abuse of Canada’s refugee system by creating conditions that would force refugee claimants to leave the country more quickly, and deter others from making an asylum claim in Canada (Canadian Doctors for Refugee Care et al. v. Canada 2014: 7-8,18). However, what emerged from the cuts was a major “unintended consequence” (Interview with Policy Analyst, 21 October 2015, Toronto). Within everyday healthcare places, such as doctor’s offices, hospitals, and walk-in clinics, refugee claimants with IFHP coverage were effectively constructed as no longer eligible for healthcare services, regardless of actual healthcare coverage. Numerous protests, campaigns, networks, and spaces erupted across the country to challenge the IFHP cuts and draw attention to the experiences of refugee claimants, which helped to contribute to its reinstatement in April 2016. In this chapter, I analyze the IFHP during this time from 2012 to 2016 within the context of Toronto’s everyday healthcare places. This is done through the lens of irregularization and borders. As this chapter asserts, borders emerge whenever and wherever

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<sup>13</sup> As part of my manuscript style dissertation, a version of this chapter was published as Connoy, L. (2018) “Borderzones the politics of irregularisation: The Interim Federal Health Program and Toronto’s everyday places of healthcare”. *International Journal of Migration and Border Studies*, v.4(1/2):144-162.



selectivity and verification controls are found, which gives rise to various categorizations and/or reduced pathways to rights. The concept is useful in my analysis of the IFHP since the program played an active role in regulating and deterring movement, and in constructing barriers to healthcare and irregular identities.

Scholars continue to challenge our conceptualizations of borders from fixed boundaries, to constantly evolving entities located within and outside of the nation-state (DeGenova 2002, 2013; Johnson and Jones 2011; Mezzadra and Neilson 2013; Rumford 2012). This chapter focuses on those borders within the nation-state, specifically within everyday healthcare places, which regulate movement and give rise to increased questioning and targeting of presence in ways that restrict access to healthcare services. I approach the problematization of presence through the assemblage of irregularization, which results in an irregular status. By connecting borders with irregularization, I demonstrate how sites (borderzones) and performances (borderwork) of borders are implicated in the irregularization of refugee claimants. Borderzones draw attention to how sites of homogeneity and consistency directly affect notions and reify limits of irregularity (Isin and Rygiel 2008; Walters 2011b), and borderwork attends to the importance of everyday actors in the enactment of borders (Rumford 2012; 2006) and consequently irregularity. It is this combination of, and relation between, elements (i.e. actors, data, documentation, knowledges, etc.) that highlights how we can conceive of borders as irregularizing assemblages.

In my approach to borders as an irregularizing assemblage, this chapter speaks to the regulation of refugee claimants within everyday places. However, assemblage also alerts us to how regulation is inconsistent, contradictory, and unpredictable (Ilcan 2013a; O'Connor and Ilcan 2001). This friction alludes to how irregularity is also struggled against by both refugee

claimants and allies. I analyze these struggles through ‘acts of liberating irregularity’, which aim to free oneself/others from irregularity through visible and less visible acts that assert presence and a right to be free from discrimination based upon one’s irregular status. This concept is developed alongside discussions of acts of citizenship (Isin 2008; Isin and Neilson 2008) and commoning (Anderson 2009, 2012; Casas-Cortés et al. 2014a) to demonstrate how these acts make a difference and enact a political subjectivity.

In light of the above, the question guiding this chapter is: How are borders implicated in the irregularization of refugee claimants, and how is this irregularizing assemblage challenged? Drawing on critical migration and border scholarship (DeGenova 2013; Mezzadra and Neilson 2012, 2013; Rumford 2006, 2012) I offer new insight into the complexity and unpredictability of borders in the Canadian context through a focus on the IFHP, and the sites and performances of borders in Toronto’s everyday healthcare places. Situating my analysis of irregularization in the Canadian context is particularly fitting because while refugee claimants are legal temporary residents, this population is increasingly subject to forms of regulation as a result of their ‘unregulated’ mobility, in ways that do not result in a change in legal status, but rather how their presence is interpreted, which effects access to services. While existing research on the IFHP focuses on its history (Dhand and Diab 2015), discourses (Beatson 2016; Harris and Zuberi 2014; Olsen et al 2014), implications on employment (Jackson 2012) health-related effects on children (Evans et al 2014) and women (Brown-Bowers et al. 2015; Campbell et al. 2014; Dorman et al. 2017; Gagnon et al. 2013; Merry et al 2011), and the implications of providers’ perceptions of the IFHP on service provision (Tastsoglou et al. 2014; Vanthuyne et al 2013), more attention is needed on its relation to borders, and to regulation and resistance more broadly.

The chapter is presented in four sections. First, I provide a conceptual overview of my approach to irregularization in relation to borders, as well as acts of liberating irregularity. Second, I detail the IFHP, which is followed by an empirical discussion of how borders are implicated in the irregularization of refugee claimants within Toronto's everyday healthcare places. Lastly, I discuss how irregularization is challenged by refugee claimants and allies through protests, the continued provision of healthcare, and word of mouth and system navigation work—what I define as ‘acts of liberating irregularity’ that work to establish common spaces and enact ‘common’ subjects.

### **Irregularization, borders, and acts of liberating irregularity**

The purpose of this dissertation chapter is to illustrate how borders can be conceived of as irregularizing assemblages. By irregularizing, I mean how borders problematize the presence of refugee claimants within space and construct it as abnormal or ‘out of place’ (see Hepworth 2014:4-7) and by assemblage, I mean the confluence of heterogeneous elements (consisting of actors, documents, policies, practices, encounters, etc.) that combine in unpredictable and contradictory ways to create irregularity. For O’Connor and Ilcan (2001:1), assemblages represent “the coming-together or the encounter of different artifacts, things, bodies, movements, sights, and sounds” in ways that “create events and the possibility of events”. To approach borders as an irregularizing assemblage draws attention to the uncertainty of events that can unfold within everyday border spaces due to the coming together of various elements. As I discuss in this chapter, the combination of standardization practices, provincial plans, and the knowledge of everyday actors, which operated in ways that verified identity and problematized presence, resulted in the attribution of an irregular status, which is not a legal status but rather a

standing or positioning that shapes lived experience by effecting the right to make claims (see Turner 1989); this status reflects one's constructed abnormal and problematic presence within space. In this regard, I understand irregularity as a type of subjectification<sup>14</sup> process that regulates access to services and resources, such as healthcare.

Analyzing irregularization in relation to the border complements discussions of borders as constructing or 'marking' bodies as 'out of place' (Johnson and Jones 2011:61). For example, Helleiner (2012) sheds light on how the 'unfriendly' Canadian border re/produces inequality and out of placeness through racial categories and identities. Critical border and migration scholars approach borders as multiscalar and multidimensional 'doings' that are located in (un)expected places within and beyond the state in ways that surround people in their daily lives (Anderson et al. 2012; DeGenova 2013; Menjívar 2014; Mezzadra and Neilson 2013; Rumford 2006). These 'doings' effectively "plac[e] people in new types of power relations with others" (Anderson et al. 2012:76) by "mak[ing] legal and social distinctions between 'nationals' and foreigners" (Sharma 2012:46) which shape "people's consciousness of who 'belongs' and perhaps more importantly, of those that do not" (Sharma 2001:417-418). The "processes, practices, discourses, symbols, institutions or networks" involved in the production or enactment of the border (Johnson and Jones 2011:62) alludes to the assemblage of the border—as entailing many elements, encounters, and relations—and to how borders pervasively materialize in ways that impact presence and rights.

Rather than approach the border as impenetrable, DeGenova (2013:1188) argues that the differentiating, ranking, and sorting function of the border reflects how it 'filters' bodies by

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<sup>14</sup> Subjectification is a form of power that seeks to regulate subjects by affecting everyday life via categorization; it is a form of power that seeks to structure or act upon others as acting subjects (Foucault 1982).

according different degrees of (mobility) rights and statuses. To view borders as a filtering mechanism reflects Mezzadra and Neilson's (2012:68) concept of differential inclusion, whereby the manner in which individuals cross or encounter the border renders them vulnerable to "varying degrees of subordination, rule, discrimination and segmentation"; for refugees, borders situate this population in vulnerable positions with limited rights (see Baban et al. 2017). In this light, the border is not encountered the same way by all people. As Rumford (2006:159) argues, "how we experience borders and how we think about borders depends very much on our personal circumstances", meaning the experience of a refugee claimant crossing Canada's border would differ drastically from that of a wealthy foreign businessperson<sup>15</sup>. The different rights and statuses that emerge from the border demonstrate the proliferation of border subjectivities, many of which are constructed as "neither fully insiders nor fully outsiders" (Mezzadra and Neilson 2012:62) but which nevertheless shape ideas of inclusion, membership, and claims to rights. I argue that one such status that emerges through the border is irregular status. In this regard, I define the border as an irregularizing assemblage which, through selectivity and verification controls, gives rise to reduced pathways to rights via the construction of an irregular status. In order to fully appreciate borders as an irregularizing assemblage, I look to the sites and performances of the border via borderzones and borderwork.

I approach borderzones as sites of homogenization and standardization that monitor and regulate populations in strategic everyday sites through mundane activities (Isin and Rygiel 2008:11; Monforte 2016; Walters 2011b:56-68). In these sites, people are identified, classified, and categorized against existing standards and norms, meaning any presence that does not reflect

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<sup>15</sup> Although this chapter does not explicitly analyze class, I acknowledge that it cannot be discounted from experiences of borders or the production of migrant categories (Schweppe and Sharma 2015:2).

the standard or the norm is deemed abnormal or irregular and subject to restrictions that may circumvent rights; for example, as I discuss below, those persons with an IFHP document within everyday healthcare places are constructed as out of place in comparison to the standardized provincial health insurance card. Here, the borderzone emerges through documents and data, which are then interpreted and compared against established standards/norms in ways that produce knowledge about the person attached to that document/data (see Bigo 2011) and impose an identity on that person. In this regard, borderzones highlight how and where irregularity is produced. For example, Inda (2011:75) frames the workplace as a borderzone which regulates and incapacitates marginalized mobile populations, specifically undocumented persons, through the raid. In my research on the IFHP, I approach Toronto's everyday healthcare places as borderzones, where—rather than the raid—data and documentation irregularize refugee claimants in inconsistent and contradictory ways, depending on for example system updates or incorrect data. Borderwork adds an important layer to this discussion of the irregularizing assemblage of borders.

Borderwork attends to how borders are performed (i.e. constructed, shifted, erased) by everyday people (Rumford 2012, 2006). This focus on everyday actors challenges commonly held assumptions of “who is responsible for making, dismantling, and shifting borders”, which is typically the state (Rumford 2012:897). Borderwork reflects Villegas' (2015a:251-252) analysis of how borders emerge through encounters with police, healthcare professionals, banks, and employment agencies, and is reminiscent of Landolt and Goldring's (2013:15) concept of conditionality work, which highlights how everyday actors shape access to rights and services by upholding or challenging various requirements. I engage with the concept of borderwork to illustrate who is involved in the irregularization of refugee claimants. Specifically, I detail how

everyday healthcare actors (i.e. doctors, nurses, frontline staff, and hospital administrators) irregularize refugee claimants based upon their knowledge and interpretation of policies, programs, and the media.

The intention of this chapter (and the dissertation) however is not to focus solely on the sites and performances of regulation through the lens of irregularization. The manner in which I conceive of irregularization and irregular status also lends to analyses of resistance (see chapter 2). Assemblage speaks to the inherent contradictions and contentions of regulation that can lead to friction (Ilcan 2013) while status is not fixed, but rather is always subject to reworking and resistance (Foucault 1982:794). To approach borders as irregularizing assemblages that are productive of irregular statuses means that borders are also marked by forms of struggle (Squire 2011:4). I analyze such struggles through the concept of acts of liberating irregularity.

Building on the influential concept of ‘acts of citizenship’ (Isin 2008; Isin and Neilson 2008; see chapters 2 and 4), being “those acts when, regardless of status and substance, subjects constitute themselves as citizens or, better still, as those to whom the right to have rights is due” (Isin and Neilson 2008:2), I define acts of liberating irregularity as visible and less visible deeds that aim to free oneself or others from irregularization/irregularity. These acts entail claims for a right to be free from the discrimination that constitutes irregularization, and assertions of presence within space. Those persons who engage in these acts create beginnings, however marginal they may be (Walters 2008:192), and as a result enact themselves as political subjects by challenging irregularization and the enclosure of space in favour of equity and justice. It is reminiscent of Johnson’s (2015:958) concept of ‘re-taking presence’ which is an assertion of the right to ‘be here’ through a political subjectivity that “populat[es] the ‘space’ of society with subjects that are in addition to the citizen”. Expressed through protests, the continued provision

of healthcare, word of mouth, and system navigation work, acts of liberating irregularity create and effect change by subtly resisting the irregularizing assemblage of borders (i.e. provincial plans and documents, standardization practices, knowledges, and actors) by calling for or creating open space and equity, and they effect change by affecting the everyday lives of refugee claimants. In this regard, I approach acts of liberating irregularity as reflecting a No Border politics that constitutes commoning (Anderson et al. 2012, 2009) and as a result, I argue the political subject that emerges through acts of liberating irregularity is the common subject (see Casas-Cortés et al. 2014a:457; see chapter 2). Below I situate this conceptual framework within the context of Toronto's everyday healthcare places, being hospitals, walk-in clinics, and doctor's offices. However, prior to doing this, I offer an overview of the IFHP to provide a foundation in which to approach the irregularization of refugee claimants within these everyday places.

### **The Interim Federal Health Program (IFHP) and the (d)evaluation of the 'bogus' refugee**

Introduced in 1957 through Order-in-Council<sup>16</sup> PC 157-11/848, the IFHP is a federally administered program managed since 1995 by Immigration, Refugees and Citizenship Canada (IRCC), previously Citizenship and Immigration Canada (CIC), that provides limited, temporary coverage of healthcare benefits to resettled refugees, refugee claimants, and other protected persons who are not eligible for provincial or territorial health insurance, or private health insurance (Government of Canada 2016b). The IFHP pays for basic healthcare, preventative/supplementary care, and coverage for most medications; while basic healthcare is equivalent to

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<sup>16</sup> Orders-in-Council are legislative instruments made by the Governor General on the advice of the federal cabinet and address a wide range of matters from civil service staffing to capital punishment. They are not discussed by Parliament before they are implemented (see Government of Canada, 2016a).



provincial coverage offered to citizens and permanent residents, supplemental and prescription coverage is equivalent to that provided to citizens or permanent residents on social assistance. The stated goal of the program is to “contribute to optimal health outcomes in a fair, equitable and cost effective manner” (Government of Canada 2006:5), however, the program was drastically amended in 2012 to reflect an increasingly securitized environment that centred on mobility and asylum (openparliament.ca; Jimenez and Crépeau 2013). On April 25, 2012, Minister of Immigration Jason Kenney announced that changes would be made to the IFHP and would take effect on June 30, 2012. On this date, the 1957 Order-in-Council was repealed and replaced with the *Order Respecting the Interim Federal Health Program, 2012*, which restricted basic healthcare coverage to refugee claimants for urgent and/or essential services, and cut coverage for supplemental benefits and medications (Government of Canada 2012a).

The changes aimed to modernize the IFHP, ensure ‘fairness’ to Canadians, protect public health and safety, manage its costs, and “defend the integrity of Canada’s refugee determination system and deter its abuse” (Canadian Doctors for Refugee Care et al. v. Canada 2014:18). For example, according to Minister of Immigration Chris Alexander:

we have no tolerance for those who take advantage of [our] generosity and consume welfare benefits and precious health-care resources. Simply arriving on our shores and claiming hardship isn’t good enough. This isn’t a self-selection bonanza or a social program buffet. [...] it’s essential that we maintain the integrity of our system for the benefit of real refugees (Government of Canada 2014a).

What is important about this statement is the use of the term ‘real refugees’. Around this time, politicians were employing the term ‘bogus’ refugees to define “persons who want to cheat the benevolent Canadian system without having grounds for a successful refugee status application” (Diop 2014:68). In contrast to the real refugee, being those persons who were resettled within Canada, ‘bogus’ refugees were those persons who moved in unregulated ways and who practiced

an ‘unsavoury’ agency (Nyers 2003:1070), proving threatening for Canadian resources and Canada’s refugee system, and therefore in need of regulation (Interview with lawyer/activist, Toronto, 7 October 2015). While the construct of the ‘bogus’ refugee was initially applied to individuals coming from designated countries of origin (DCO)<sup>17</sup> or ‘safe’ countries, it came to effectively shape how refugee claimants in general were imagined. As Weber and Bowling (2004:198) argue, declaring refugee claimants as ‘bogus’ not only accompanies coercive measures but heightens suspicions about the identities and intentions of this population (see for example chapter 4). As I detail below, the construct of the ‘bogus’ refugee came to justify the restrictions applied to this group in the area of healthcare and shape how refugee claimants were encountered in everyday healthcare places.

The 2012 IFHP situated refugee claimants into various categories of coverage that were hierarchically ranked according to status and country of origin. The categories were: expanded healthcare coverage; healthcare coverage; and public health and public safety (PHPS) coverage. Refugee claimants not from a DCO received ‘healthcare coverage’ which includes most services received from a doctor or nurse, limited access to diagnostic tests and hospital services, and no medication except to prevent or treat a disease or condition that poses a public health and safety threat. Refugee claimants from a DCO received PHPS coverage, which only provides coverage for medications or services that prevent or treat a public health and safety threat (Government of Canada 2012b). This meant that life-sustaining medications, like insulin, were no longer covered.

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<sup>17</sup> Designated Countries of Origin (DCO) are deemed ‘safe’ by the Canadian government because they “do not normally produce refugees, but do respect human rights and offer state protection”. There are currently 42 countries listed as safe by the Canadian government, including controversial countries such as Mexico and Hungary. This category was introduced to control and deter refugee claims in the country. Claimants from a DCO have their claims processed significantly faster than non-DCO claimants (Government of Canada 2013b, 2017).

Through the IFHP, dimensions such as nationality or country of origin were accorded different valuations that played a role in the positioning of refugee claimants with regards to access to healthcare coverage. Another important dimension included how one crossed Canada's border.

Refugee claimants in Canada can make claims for asylum in the country in one of two ways: port of entry or inland<sup>18</sup>. Port of entry claims are made upon landing/entering Canada at airports, seaports, or land border crossings<sup>19</sup>, while inland claims are made at IRCC offices after one has crossed the border. Prior to the cuts, port of entry claimants received their IFHP coverage almost immediately while inland claimants would receive an acknowledgement of claim document that provided temporary IFH coverage until the date of their eligibility hearing. After 2012, inland claimants were no longer issued this document, meaning they did not have coverage until their eligibility hearing (*Canadian Doctors for Refugee Care, et al. v. Canada* 2014:41), which could take up to two months. A refugee claimant reflects on the uncertainty and anxiety this creates:

if someone has no money, no ID, then what will you do? That's a problem because if you reported after landing here, then you will get ID after two months, what will happen in between these two months? That's a big problem. And after getting the ID, that is not including teeth and eyes. That's a big problem. It's very costly here. (Interview with Refugee Claimant, Toronto, 11 March, 2016).

This quote highlights the uncertainty that surrounds one's health during the waiting period, especially dental and vision care. Having little ability to pay for such expenses out of pocket can lead to deteriorations in the health of refugee claimants or it may affect their ability to work or go

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<sup>18</sup> When an individual makes a claim at a port of entry, they receive a Basis of Claim (BOC) Form and a Notice to Appear for a Hearing; the BOC must arrive at the Immigration and Refugee Board (IRB) no later than 15 days after the claim was referred. If a claim is made inland, the BOC form is submitted at that time to the officer who then decides if the claim is eligible to be referred; if so, they receive a Notice to Appear (IRB 2016a).

<sup>19</sup> The Safe Third Country Agreement deters asylum claims at the Canada-US land border.

to school (Jackson 2012). It can be assumed that port of entry claimants were prioritized over inland claimants because the former group makes their asylum intentions known immediately at the border, while the latter may be perceived as withholding this information which is not looked favourably upon by the state.

If an inland refugee claimant required healthcare services within the two month timeframe, the fees for the service must be paid out of pocket. According to one refugee claimant:

I have a friend who got sick before he got the [certificate] and he had to pay for the medication. Yeah, he was very sick [...] He was turned down from all the places he went. But he got a doctor at some clinic that offered to treat him but he had to pay, but he had no option, he paid for the treatment. Probably around one hundred and thirty dollars (Interview with Refugee Claimant, Toronto, 11 March, 2016).

Pregnant refugee claimants who claimed asylum inland were particularly affected by this change.

As one doctor states,

we've seen women who have arrived in the country, didn't know they had to claim at the port of entry, walk through customs [...] but then had to wait until they meet an eligibility officer six weeks later, but they're pregnant and due in the next six weeks (Interview with Doctor, Toronto, 20 October 2015).

An Executive Director of a prominent refugee organization in Toronto tells a similar story:

We have a woman that, she came from Africa and she came six months pregnant, and with that she came with malaria. We have to put her in the hospital [...]. She received a bill of \$26,000 [...] because in the meantime that she got the malaria, she was claiming refugee and in the meantime that she was at the hospital [...] she didn't have IFH, [...] and that's the problem because it's a gap and it's overwhelming and that's unfair because this woman, [...] if she is accepted, she starts her life in Canada with a bill of \$26,000 (Interview with Executive Director, Toronto, 20 October 2015).

While the differentiation between inland and port of entry claimants reflects the criminalized presence of those refugee claimants who do not claim at the border, the overall healthcare cuts speak to how the government was “getting out the message” that a refugee claimant who arrives

on their own volition, “is somehow doing it wrong, is jumping a queue, is illegal, is bogus, etcetera” (Interview with Lawyer, Toronto, 7 October, 2015); this demonstrates how labels create distinctions and differentiations, and restrict the allocation of rights (Zetter 1999:2,8, cited in Chimni 2000:254; Gorman 2017). For those who came on their own volition, and made an inland claim, they were subjected to increased anxiety not only during the process—by having to pay for costly fees—but also after the process, because of possible debts incurred as a result of not having access to healthcare coverage.

The Canadian Doctors for Refugee Care (CDRC), the Canadian Association of Refugee Lawyers (CARL), Justice for Children and Youth (JFCY), and two refugee claimants, Daniel Garcia Rodriguez and Hanif Ayubi, brought the Canadian Government to Federal Court to challenge the legality of the IFHP changes. They argued the cuts were unconstitutional and inconsistent with Canada’s international obligations to refugees, as stated in the *1951 Refugee Convention* and the *Convention on the Rights of the Child*. They also argued the cuts were in violation of Section 7 (the right to life and security of the person), Section 12 (cruel and unusual treatment), and Section 15 (discrimination) of the *Canadian Charter of Rights and Freedoms* (Canadian Doctors for Refugee Care, et al. v. Canada, 2014; CARL, 2013)<sup>20</sup>. On July 4, 2014, the Court ruled the cuts were in violation of Sections 12 and 15 of the *Charter*, with the Section 12 ruling of ‘cruel and unusual treatment’ constituting a first in a non-criminal case. The ruling is important for those challenging cuts to social programming since previously there had been little

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<sup>20</sup> Section 7 states “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”; Section 12 states “everyone has the right not to be subjected to any cruel and unusual punishment or treatment”; and Section 15 states “every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability” (Government of Canada 1982).

success in this realm (CARL 2014a; Voices-Voix 2014). The Court ordered the federal government to draft a new *Charter*-compliant IFHP within a four-month timeline. The government appealed the ruling and requested to suspend the decision until the appeal was heard, which the Federal Court of Appeal denied, ruling “the harm of continuing to deny refugees health care pending the resolution of the government’s lengthy appeal was greater than the inconvenience of requiring the government to reinstate the IFHP” (CARL, 2014b). As a result, on November 4, 2014, the Government introduced the ‘temporary’ Interim Federal Health Program.

The ‘temporary’ IFHP restored benefits to pregnant women and children and gave all refugee claimants regardless of country of origin coverage for laboratory and diagnostics, doctor and hospital services, and medications to treat public health and safety risks (Government of Canada 2014b). The victory was short-lived however because the program continued to maintain separate hierarchical categories of healthcare coverage (with refugee claimants receiving ‘type 3’ coverage) which maintained confusion amongst healthcare professionals, and cemented the image of refugee claimants as individuals who could not or should not be served, the latter of which was a major unintended consequence of the IFHP changes. Even for those refugee claimants who gained coverage after 2014, many faced continued denial to healthcare services. As one interview participant notes, “people who continued to have IFH coverage could be refused care, and it was partly because [...] there was so much political rhetoric around bogus refugees who were being made ineligible for care” (Interview with Policy Analyst, Toronto, 21 October 2015). This unintended consequence offers insight on how irregularization as an assemblage operates. Furthermore, the changes made to the IFHP illuminate how borders proliferate, specifically internal borders, that aim to “deter, stop, or control migratory flows”

(Menjívar 2014:360) and “serve to establish difference, [and] creat[e] new forms of social stratification” (355). The increased need to target refugee claimants within everyday healthcare places contributed to the irregularization of refugee claimants. Below, I situate the IFHP within Toronto’s everyday healthcare places to demonstrate how refugee claimants were irregularized.

### **The sites and performances of borders: borderzones, borderwork, and the production of irregularity in Toronto’s everyday healthcare places**

Reflecting my conceptual framework, I approach this section through the sites and performances of borders, being borderzones and borderwork, to highlight how irregularity is produced and experienced in the everyday.

To view everyday healthcare places as borderzones draws attention to the importance of standardization via data and documentation, and its connection to irregularization. In Ontario, citizens and permanent residents receive healthcare coverage through the province’s Ontario Health Insurance Plan (OHIP), which is verified through an OHIP identification card. Similar in look and size to a driver’s licence, the OHIP card provides a photo of the holder, their signature, birthdate, sex, a 10-digit identification number, the issue date, and the expiration date. This card should be presented to frontline staff at every visit to a healthcare centre to demonstrate that the holder is insured through the province; this is typically achieved by swiping the card through a card reader, or manually typing the identification number through an online program, that verifies the card in real-time (OntarioMD 2017). As long as the card is valid that is the extent of the process; sometimes, after the initial presentation of the card at a location, it does not need to be shown again. The IFHP operates differently since it is a federal program. Upon entering a healthcare facility, refugee claimants present their Refugee Protection Claimant Document (RPCD) to medical staff. The RPCD is a printed document “that identifies the person as a client

of Canada’s refugee protection system” and “indicate[s] that the person is eligible for coverage under the Interim Federal Health Program” (Government of Canada 2014c). However, because the IFHP is not technically a standardized program within everyday healthcare places, not all doctors are registered to provide services, meaning that refugee claimants must find an IFHP registered physician in order to receive healthcare services.

Unlike the OHIP card, the RPCD has similar dimensions to legal size paper. It provides similar information like the OHIP card: name, birthdate, photograph, an eight-digit client identification number, country of birth, country of citizenship, the date the document was signed, the document’s expiration date, as well as additional legal information detailing the purpose of the document. The most important information on this document is the eight-digit client identification number that verifies whether or not the person is eligible for services. This number is verified by medical staff by contacting Medavie BlueCross (the insurance company that administers the program), either by phone or online at every visit prior to receiving services (Medavie Blue Cross 2014:6). Confirming an identification number may take time if the system is being updated, which can create backlogs in the waiting room (Interview with Director of Policy, Toronto, 21 October, 2015). Determining the level of coverage can also create backlogs.

As a doctor elaborates:

when there’s forty people waiting in your waiting room that you’re going to see during that day and you’re trying to figure out what country someone came from, and what public health public safety coverage means, I think people just said you know what, go somewhere else (Interview with Doctor, Toronto, 19 October, 2015).

Cases also exist of BlueCross denying valid requests as a result of communication and administrative problems (Barnes 2013:6). In addition to contacting BlueCross, staff must also confirm the identity of the patient either by the photograph on the document or through another



government issued photo ID (Medavie Blue Cross 2014:9). Once the patient is confirmed as having coverage, services may be provided.<sup>21</sup> After the patient is treated, the provider must submit a claim that includes the client's information and their identification number, the medical professional's information, and claim information. They must also fill out the appropriate claim form that applies to that particular health benefit, agree with the Terms and Conditions and confirm that the claim is true and accurate, sign the form, and have the client sign the form (if submitting a paper claim form) (ibid:15). Although healthcare professionals also provide similar information when submitting an OHIP claim (Ministry of Health 2015:4-5), the main issue is that the IFHP is a separate process, entailing different forms, types of coverage, procedures, documentation, reimbursement, and governing bodies.

In contrast to the normal/standard OHIP card that complements the operating procedures of everyday healthcare places, the IFHP represents something that is fundamentally different and irregular. The abnormality of the document within healthcare places can confuse front line medical staff (Interview with social worker, Toronto, 26 November 2015) in ways that either delay access to healthcare services for patients or result in denied access to services. In other places, IFHP recipients may not be denied, but instead asked to pay fees in order to access services, alluding to the contradictory and inconsistent outcomes that define irregularization. In this sense, the document embodies a 'thing-power' which "*does something, [...] perform[s] actions, produce[s] effects, and alter[s] situations*" (Bennett 2004:354-355). Arguably, the 'thing-power' of the document, and its coinciding data, work to construct an identity of its holder, in that the inherent irregularity of the document effectively irregularizes its holder within that

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<sup>21</sup> However, if a service requires prior approval, such as prosthetics, or some forms of dental care or therapy, providers must consult the IFHP Benefits Grid and then submit a prior approval request to BlueCross (Government of Canada 2011; Medavie Blue Cross 2014:15).

space; the thing-power works to create irregularity. The manner in which the IFHP document constructs divisions, and constitutes restrictions to services, demonstrates how it may be conceived of as a ‘paper border’ (Rajkumar et al. 2012:486). The personal, numerical, and categorical data that constitute the IFHP—presented through codes, charts, and grids—operate as standardization practices that constitute the healthcare borderzone; this data and documentation works to verify and construct identities and reduce pathways to healthcare. Scholars have demonstrated how numbers, charts, and grids shape knowledge (Iltis 2013; Iltis and Lacey 2015; Iltis and Philips 2010; O’Connor et al. 2014), and this chapter demonstrates how it produces irregularity. But, data and documentation are also interpreted by frontline staff and medical professionals, highlighting how these everyday actors are involved in ‘borderwork’.

Medical professionals shape access to services based upon their knowledge and interpretation of policies, procedures, data, and various discourses, which can have very real (and oftentimes violent) implications on the health and wellbeing of refugee claimants. Many times, doctors will interpret the IFHP in ways that deny all recipients access to their services. A doctor speaks to this issue:

There’s doctors that are not registered [for IFHP coverage] and then there’s probably some doctors that have chosen on purpose to not register, which are two separate things in some way. We came across this with a dermatology clinic that I sent a patient to, that I send most of my other patients to who have OHIP, and they refused to see him, and they said “We’re not an IFH provider”, and apparently that’s allowed—that they can just say that they don’t provide IFH, that they don’t serve this population (Interview with Doctor, Toronto, 20 October 2015).

In this example, the dermatologist engaged in a form of borderwork by constructing barriers to healthcare. Here, they actively selected IFHP recipients as not eligible for services based upon their construction of such recipients as different from the norm (i.e. OHIP). This type of discrimination that emerges through the IFH program is constitutive of irregularization.

Pregnant women were particularly targeted by medical professionals. According to many participants, these women were constructed as a group who could not and/or should not be served. As a Program Manager expresses,

we've had doctors say "well, this person's a refugee claimant. They're going to have their claim heard while she's pregnant. I can't fire her as a patient once she's my patient. So, if she ceases to be eligible for healthcare, I'm on the hook. So, I won't take her to begin with" (Interview with Program Manager, Toronto, 8 October 2015).

The fact that refugee claimants' IFHP coverage could change at any time transformed this group into risky bodies, but for pregnant women who required longer-term care, they were determined to be even more risky, which the above quote exemplifies. Drawing on Tyler (2013:217), the experiences of pregnant refugee claimants highlights how women's bodies constitute biopolitical sites of policing, management, and control—or 'corporeal border zones'—that should not be separated from the sovereign desire to manage "the undesirable reproduction of non-citizens". These above examples yield insight into how medical professionals engage in borderwork and effectively construct irregularity. In this regard, these examples demonstrate how healthcare professionals can be conceived of as border guards (Ticktin 2011a:127) or gatekeepers (Villegas 2013b:221,224) of the threshold from which claims can be made. As Ticktin (2011a:127) argues, the medical realm is an important site of power where bodies are judged, and where "new forms of subjectivity and inequality" are produced. Consider for example the case of a pregnant Mexican woman who claimed asylum in 2012, just prior to the cuts (meaning she had full healthcare coverage) but was told that she had to pay a \$2,600 'uninsured fee' at a Toronto hospital. Upon learning that the woman had full coverage, the hospital administrator still required that she sign a waiver that rendered her responsible for any fees incurred during the birth of her child. The anxiety this created led the woman to opt for a homebirth attended by a

midwife, even though she felt unsafe with this option (Marwah 2014:10). One of the key elements in the irregularization of this woman was the country of origin information listed on her RPCD. Since Mexico is a DCO, the administrator was more influenced by this, and its relation to ‘bogusness’, than the actual coverage itself, highlighting how the administrator participated in borderwork and how the ‘data double’ gains a type of autonomy and realness separate from the individual (Bigo 2011:32); both of these are implicated in the construction of irregular subjects. Here, the IFHP/RCPD operated in a way that inscribed a certain subjectivity that ‘fixed’ this woman as not belonging to Canada or the space of the hospital, and as not eligible for services even though she was a legal resident with full healthcare coverage.

The borders that refugee claimants encountered were not limited to healthcare places; rather, these borders followed them. For example, female refugee claimants have been threatened with collection agencies if they are unable to pay the cost of giving birth. According to a Program Director of a refugee shelter,

those bills will not go away, they will actually sit there, and the person’s actual financial standing in their lifetime, if they should stay here, they would have to carry this forward until they deal with it at some point. So, the whole settlement navigation process becomes very difficult because [...] these letters are coming and they are threatened with court action by the small claims or whatever, so they don’t know what to do (Interview with Program Director, Toronto, 22 October, 2015).

If refugee claimants cannot pay a hospital service bill, which can range from a few hundred to thousands of dollars, then the hospital will stop providing services until the person pays, or they “send collections agencies after people” (Interview with Doctor, Toronto, 20 October, 2015). Not only does the above case situate collections agencies within the broader discussion of borderwork, but it also demonstrates the lived experience of the border within everyday life (Nyers 2013:40). While other hospitals will notify patients of outstanding bills or offer

repayment plans, sometimes of a minimum of \$5 per month, it is important to acknowledge how long it may take to pay off the bill and the prolonged stress that constant reminders and outstanding payments create.

To avoid stress, some refugee claimants may self-treat (Interview with refugee claimant, Toronto, 18 October 2015) or avoid seeking care services altogether. Avoiding healthcare treatment is a result of not only the anxiety of fees or possible denials, but also of state retribution. As one doctor explains,

I've even had patients that have asked me if the government will know that they're seeking healthcare services and whether they should not seek them because maybe the government will then think that they're costing the system too much and then they will not approve their refugee claim. So, there's a lot of fear, there's a lot of uncertainty (Interview with Doctor, Toronto, 20 October, 2015).

This quote highlights how the irregularizing assemblage of the border successfully regulates the conduct of refugee claimants in the form of avoiding healthcare services. Furthermore, it alerts us to how refugee claimants realize their irregularity and vulnerability to borders, in ways that are reminiscent of DeGenova's (2013:1188) concept of deportability, a disciplinary border mechanism that entails the realization of one's vulnerability to borders, specifically to deportation. Perhaps the most shocking realization of one's irregularity is evident in cases of a refugee claimants who rescind their asylum claim. According to a settlement worker:

I have had cases in which people said "okay, I have been trying to see a doctor for last six months, I'm going back to Czech Republic because I am running out of medication that I was issued in Czech Republic which works for me" (Interview with Settlement Worker, Toronto, 15 October, 2015).

Such cases arguably constitute *refoulement*, in that by denying the right to healthcare, refugee claimants are forced into a position of returning to their country of origin, which may put their life at risk (Edwards 2005:322). However, by working within this chapter's conceptual

framework, I am also aware of how the irregularizing assemblage of borders are challenged. I detail such struggles below.

### **Acts of liberating irregularity**

Engaging with the concept of acts of liberating irregularity, this chapter illustrates how irregularized refugee claimants and their allies resist irregularization through protests, the continued provision of healthcare, word of mouth, and system navigation work. I argue they represent claims and assertions of presence and a right to be free from the discrimination that constitutes irregularity. Such ‘audacious affirmations’ (DeGenova 2010:103) fundamentally challenge the idea of refugee claimants as non-members of society by indicating relations and connections within the community through one’s occupation of space (Varsanyi 2008:39-40). Through such acts, a political subjectivity is enacted amongst subjects who constitute themselves (or are constituted) in a manner different than that accorded to them—the common subject. These political subjects challenge differentiation and inequity and refuse the enclosure of space in favour of open space, or common spaces (see: Anderson et al. 2012; Casas-Cortés et al. 2014a; chapter 2). Consider for example a statement made by an Executive Director of a refugee shelter where ad-hoc primary healthcare services are provided:

I think it’s the most important, to have that right [to see a doctor]. [...] They [refugee populations] feel that they don’t have all the rights and that’s not true. I believe that anyone living in Canada, they have rights (Interview with Executive Director, Toronto, 20 October 2015)

Here, the common subject emerges through claims of a right to healthcare for all persons in Canada. Through this assertion, the Executive Director opened up the space of the shelter to include a primary healthcare clinic for un(der)insured populations. The acts I discuss below demonstrate how, through solidarity, refugee claimants and allies work towards health equity by

challenging the unjust categorizations and statuses that constitute irregularization.

Public protests, campaigns, press conferences, occupations of government spaces, and interruptions of government officials occurred throughout Toronto (and across the country) between 2012 and 2016 to challenge, and draw public attention to, the IFHP cuts. For example, on 15 June 2015, protestors in Toronto participated in the largest *National Day of Action* that called on the federal government to rescind the IFHP amendment; here healthcare professionals, refugee claimants, and other migrant groups and allies informed the public of the IFHP cuts through stories and flyers. On 11 May 2012, ninety physicians occupied Minister of Natural Resources Joe Oliver's Toronto office and presented a signed letter by the medical community detailing their concerns and their call to end the cuts (Docs4refugeehc, 2012). Numerous campaigns also erupted such as: the *Non-Cooperation Campaign* (launched by the grassroots organizations of *Health for All* and *No One Is Illegal* on 15 July 2012), which entailed the declaration of healthcare professionals to continue to provide healthcare services to refugee populations (Keung 2012), representing an extension of professional duty through small acts of resistance against irregularization; the *Fill the IFH Gap* campaign launched in January 2013 that urged the Ontario government to fill in the gap created by the cuts (OCASI, website); and *OHIP for All*, a multidisciplinary grassroots collective which launched in the aftermath of the reinstatement of the IFHP to call on the provincial government to provide OHIP coverage to all residents of Ontario, regardless of status (OHIPforAll website).

These protests and campaigns interrupted designated government spaces, portrayed government actions as irresponsible and uninformed, and produced breaks within given understandings and practices of healthcare by acknowledging and asserting the presence of refugee claimants and their right to healthcare. In the case of doctors who occupied MP Oliver's

office, the ‘white coat’ was politicized by inserting it into spaces outside of the healthcare setting in quite visible and confrontational ways. Perhaps this can be conceived of as a politicized exaggeration of the doctor with the ‘white coat’ who is the protector, authority figure, and trusted expert of health and medicine. In this light, these visible acts of liberating irregularity reflect acts in that they “instantiate ways of being political” and rupture “given orders, practices, and habitus” (Isin 2008:36). In addition to coalitions, campaigns, and protests, the provision of medical aid to refugee claimants represents another important act of liberating irregularity.

The provision of medical aid to refugee claimants, and other un(der)insured populations, occurs within various spaces across Toronto, including Crossroads Refugee Clinic, Community Health Centres (CHCs), and Midwife Clinics. Created in 2011, Crossroads Clinic is Toronto’s first hospital-based refugee health clinic that provides primary care to refugee populations for their first two years in Toronto; afterwards they are connected with a family physician (Women’s College Hospital website). CHC’s are not-for-profit organizations that deliver free primary care services in combination with other wraparound services, such as community development, health promotion, and illness prevention through health and social service agency partners, to residents of specific catchment areas, regardless of status (AOHC website). Many participants from this dissertation project stated these centres are amongst the most important healthcare providers in the area of refugee health<sup>22</sup>. As one social worker states:

We do rely a lot, I know I do, on community health centres. If I’ve got a client who’s a refugee claimant, I don’t even bother with the private doctors or trying to find a private doctor and calling them one by one saying “Do you accept IFH? Do you accept IFH?” [...] It’s too time consuming. It doesn’t make any sense. I’ll get them connected to the local community health centre that serves their catchment area (Interview with social worker, Toronto, 26 November 2015).

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<sup>22</sup> Although noted as among the most important healthcare actor in Toronto, CHC’s are far from perfect. Patients face extended wait times and only primary healthcare is offered here.



Since 2013, CHCs have developed agreements with hospitals to allow CHC patients to access inaccessible hospital services by covering the costs of hospital registration fees (Perry and Katawazi 2014). According to one doctor, these agreements have been particularly important for pregnant refugee claimants (Interview with Doctor, Toronto, 20 October 2015). However, CHC-hospital agreements are not always accessible. Patients must be connected to a CHC or social worker who knows of these agreements, reflecting Villegas' (2013b:221) argument on the "insecure and negotiated quality of access to health care [...] [that] characterizes the lives of precarious status migrants in Canada". Finally, Midwives offer free pre- and post-partum services to pregnant residents of Ontario regardless of status and assist patients in making connections in the community, mostly with CHCs. A birth centre was also opened in Toronto in 2013 that enables uninsured women to give birth without fear of lab test, ultrasound, and hospital fees (City of Toronto 2013:12; see Toronto Birth Centre, website). Also, both CHCs and midwives have also developed agreements with hospitals that allow clients to access specialists or delivery rooms within the hospital without the risk of high fees or bills. While these examples are reflective of system navigation work (see below), I argue they are also examples of 'common' spaces that practice a No Border politics. Here, the problematization and categorizations that constitute irregularizing border assemblages are rendered obsolete by prioritizing the healthcare rights of commoners and the entitlement of all persons to not be excluded or distinguished from others (see Anderson et al. 2012:-84-85).

Alongside these visible acts of liberating irregularity are 'word of mouth' and system navigation work. 'Word of mouth' is a subtle act of information sharing among allies and refugee populations to assist in navigating the healthcare system and creating/finding spaces of

(health) equity without direct attention from governing/migration authorities. According to a doctor who works with refugee claimants and other un(der)insured populations in Toronto,

There's a lot of advocating on behalf of the individual that's involved. There's often a lot of finding back channels of who is willing to see somebody and not bill or who's willing to see somebody and bill less and finding ways [...] for us to pay for things for people (Interview with Doctor, Toronto, 20 October, 2015).

Word of mouth includes speaking with allies, or attending meetings and seminars, where information is shared on policy or practices and then relayed to refugee claimants and colleagues (Interview with Program Manager, Toronto, 22 October, 2015). It can also include having social workers, lawyers, and other refugee allies “go to the places where newcomers go” such as schools and apartment buildings, to “knock on doors and hand out flyers” (Interview with Program Manager, Toronto, 8 October, 2015), or when refugee claimants share their experiences with friends, family members, or settlement/healthcare professionals and make known important information on city services and resources. One social worker elaborates, “it's really just people in the community saying I had a very good experience at this agency or I had a really good experience with this worker, go see them, or that agency has a worker that speaks our language” (Interview with Social Worker, Toronto, 26 November, 2015). By sharing such important pieces of information with others, refugee claimants are asserting their right to access healthcare; rather than voiceless victims (see chapter 5), refugee claimants use their voice to assert their presence and as a result, enact themselves as common subjects, as subjects who open up space in ways that transgress differentiation and discrimination.

Word of mouth is reminiscent of other analyses of resistance within migration scholarship, such as for example the concept of the ‘mobile commons’ where people on the move create, share, use, and contribute to “a world of knowledge, of information, of tricks for survival, of mutual care, of social relations, of services exchange, of solidarity and sociability”

(Papadopoulos and Tsianos 2013:190). For Trimikliniotis et al. (2016:1041), commoning entails the transmission of knowledge through word of mouth, and they demonstrate how word of mouth transcends border controls in the Greek context. Word of mouth also complements Ilcan's (2013:199) argument on knowledge; while knowledge can classify and differentiate people in ways that create injustice, the exchange of knowledge also yields the potential to challenge unjust classifications and make possible new spaces for politics and 'acts of social justice'. The subtlety of word of mouth alludes to the importance of attending to less visible acts (Ataç et al. 2015; Johnson 2012; Ní Murchú 2016) particularly in an era of increased securitization.

Word of mouth is an element of system navigation work, the latter of which entails the careful traversing of various pathways to seek out and gain access to services. A refugee claimant details how they practiced system navigation work in the city:

in my case, the first place I went [...] they told me they don't deal with those piece of papers [for the IFHP]. I have to have, they were calling it OHIP or something, and I didn't have that, so at least they directed me to another place where they accepted it. [...] so they sent me to another walk-in clinic who treated me but they never took me as their patient. So, then I went into the internet and got the [information for a clinic that serves IFHP and other un(der)insured individuals] and then went there and they took me as their patient (Interview with Refugee Claimant, Toronto, 11 March, 2016).

Another example includes a pregnant woman who, after being denied care by an obstetrician unless she paid \$3000, navigated the system until she received the care she believed she deserved:

she went to the hospital, she went to midwives, she went to community health centres, no one would take on her care. Finally, her lawyer asked her to come and see us. She wasn't a patient of ours, and although she was quite distraught, it was obvious that she was an incredibly resourceful woman (Interview with Doctor, Toronto, 19 October, 2015)

While these examples are not 'momentous' they nevertheless establish refugee claimants as rights bearing common subjects who create change in their own lives. System navigation

complements Johnson's (2014:200) argument that the activism of precarious status noncitizens, such as refugee claimants, is 'ongoing' and occurs within the everyday. Regardless of the degree of transgression or systemic transformation, refugee claimants are actively involved in the liberation of their own irregularity through "everyday practice[s] of refusing the border" (Anderson et al. 2012:82,86), which highlights how irregularization can also be a starting place for politics.

## **Conclusion**

Approaching irregularization as an assemblage of heterogeneous elements (i.e. policies, practices, documents, actors, knowledges, encounters, etc.) that target and question presence, this chapter engaged with critical migration and border scholarship to offer insight on the intricate connection between borders and irregularization and how borders can be conceived of as irregularizing assemblages. This was achieved by focusing on the sites (borderzones) and performances (borderwork) of borders. In addition to this focus on regulation, the chapter offered insight on how irregularization is also a starting place for politics, being political acts and political subjects. I analyze these through the concept of acts of liberating irregularity, defined as deeds that challenge irregularization through the assertion of presence. In the next chapter, I continue to build upon my approach to irregularization through a more detailed engagement with (non)citizenship and its relation to the construction of an irregular 'other' status.

## Chapter 4

### **The Irregularity of Refugee Claimant (Non)Citizenship: Discrimination and Solidarity in Toronto's Everyday Healthcare Places**

Beginning June 2012 until April 2016, refugee claimants in Canada faced restricted or denied access to healthcare coverage to deter individuals from making an asylum claim and to force those already in the country to leave more quickly (Canadian Doctors for Refugee Care, et al. v. Canada 2014: 7-8,18). This coverage is offered through the Interim Federal Health Program (IFHP), a federal healthcare coverage program provided to refugee populations and other vulnerable groups in Canada. In the last chapter (chapter 3), I analyzed the IFHP through the lens of the border to understand how the regulation of refugee claimants is exercised and experienced in the everyday. In this chapter, I continue to build on this analysis but through an alternative lens—citizenship. Through the lens of citizenship, I analyze how, between 2012 and 2016, the presence of refugee claimants within Toronto's everyday healthcare spaces was irregularized, regardless of legal status and level of coverage.

The citizenship literature offers much insight on irregularity. Citizenship, and affiliated notions of rights, membership and belonging, emerges in relation to 'others', or more specifically through encounters with others (Isin 2002). Through these encounters, ideas of citizenship and noncitizenship emerge and are (re)defined, and subjects are (re)constituted as such (Hepworth 2014; Landolt and Goldring 2013), regardless of actual legal status. For Chun (2016:381), this "lived experience of citizenship reflects a [...] process of subjectification" in which various factors and dimensions come together to "determin[e] who does and does not belong to a national polity". Drawing on critical citizenship and migration scholarship (Isin 2002; Johnson

2012; Landolt and Goldring 2013; Sharma 2001) I analyze how the constructed ‘otherness’ of refugee claimants can be understood through the lens of irregularity.

Irregularity is a positioning that emerges through irregularization, which I define as an assemblage of heterogeneous elements (i.e. actors, documents, policies, practices, encounters, etc.) that come together in unpredictable and contradictory ways to problematize and construct presence as ‘out of place’ (Hepworth 2014) or irregular. Within the conceptual context of citizenship, I argue that those who are constructed as irregular represent an abnormal presence within spaces that prioritize citizenship. This idea of the irregular other is a fundamental element of the history of citizenship (McNevin 2011:15-16). As Hindess (2004) notes, citizenship is an exclusive subjectivity that produces hierarchies and marginality. The purpose of this chapter is to demonstrate how we can conceive of citizenship as an irregularizing assemblage that consists of identity documents, representations, and encounters that work to irregularize persons/groups. Through this lens, this chapter sheds light on the complexity and inconsistency that is inherent to constructions and experiences of (non)citizenship (Landolt and Goldring 2015).

In addition to this focus on regulation, irregularization also provides the space to analyze friction and contestation, and therefore complements current discussions of how (non)citizenship is contested (Isin 2002, 2008). This chapter offers insight on such challenges through ‘acts of liberating irregularity’ which resist irregularization/irregularity through acts founded on solidarity and performativity. Focusing specifically on allies, in this chapter I argue that acts of liberating irregularity entail political resubjectifications of refugee claimants that speak to their presence and rights (see Castañeda 2013), and enact allies as ‘common’ subjects who challenge the enclosure of space and actively construct common spaces that prioritize equity and justice

(see chapter 2; Casas-Cortés 2014a). In this regard, I approach citizenship as an irregularizing assemblage that entails both regulation and resistance.

In light of the above, the key question guiding this chapter is: how is irregularity a construct of the relationship between citizenship and noncitizenship, and who is the political subject that challenges irregularity? Answering these questions within the context of the IFHP offers new sociological insight into the healthcare experiences of refugee claimants in Canada, contributes new understandings of noncitizenship within the Canadian context (Bhuyan 2012; Goldring and Landolt 2013; Villegas 2015a, 2013), and alerts us to the importance of solidarity (Castañeda 2013; Johnson 2015, 2014).

The chapter is broken down into five sections. The first section introduces my conceptual framework that combines critical citizenship scholarship with irregularization, which is then followed by an overview of my understanding of acts of liberating irregularity. The third section provides an overview of the IFHP, and the fourth section offers an empirical analysis of the IFHP in Toronto's everyday healthcare places from 2012 to 2016. I conclude with an empirical analysis of acts of liberating irregularity, specifically through policy and place.

### **Irregularization, Citizenship, and the Irregularity of Precarious Noncitizenship**

Citizenship is conventionally understood as a legal and political institution that entails a collection of rights and obligations which give members of a political community (typically the nation-state) a formal legal identity (Turner 1997:5,7). However, critical citizenship scholars are broadening this conceptualization of citizenship due to Isin's (2002, 2008) influential genealogical work. Considering its importance in the literature, I outline his approach to citizenship below.

Isin (2002:ix) argues that citizenship is an invented and inherited phenomenon that is narrated by dominant groups who articulate their identity in relation to others, being strangers, outsiders, and aliens. For him, the formation of citizens and others involves relations of power that are exercised through strategies and technologies of citizenship (such as stigmatization, marginalization, enrolment, membership, symbols, rites, rituals, and images) which constitute citizens as virtuous and work to legitimize the inheritance of citizenship. Isin's approach to citizenship challenges conventional understandings of citizenship from a static identity to that of alterity, whereby citizenship emerges in relation to otherness or noncitizenship. In this light, noncitizens are included in the realm of citizenship, rather than located outside of it; the formation of others is internally related to citizenship (Isin 2002:4). For example, the production of the Canadian citizen activates and is activated by the noncitizen (Sharma 2001:418-419). The inclusion of noncitizens within the realm of citizenship means the relations of power that govern the conduct of those subjects that constitute it also govern over the noncitizen. Hence the importance of citizenship for my dissertation research which aims to come to terms with how refugee claimants, who are precarious status noncitizens, are regulated and subjectified as such.

In order to understand how citizenship is implicated in the construction of irregular status, attention must be placed on how the formation of 'others' occurs. For Isin (2002), the formation of others occurs through encounters within space. Encounters "require the presence and recognition of other groups" to realize oneself (Isin 2002:49), which lead to the development of technologies that immobilize or constrain others (25-26). The attribution of otherness entails assigning a standing from which others are less able to make claims. I view otherness as similar to irregularity, being a status, standing, or positioning that is hierarchically ranked based upon "variable and complex" dimensions (see Turner 1989:2-3) and which impacts one's ability to



make claims in space, such as claiming a right to healthcare. As a result, I argue for a conceptualization of the ‘other’ through the lens of irregularity, or rather, to conceive of the ‘other’ as reflecting irregular status. To view otherness along the lines of irregularity offers insight on how encounters, and the various relations and elements that shape them, are important sites in which to analyze irregularity. In this light, I approach citizenship as an irregularizing assemblage that is productive of irregular positionings or subjects which has implications on everyday life and wellbeing.

Perhaps the next question emerging from this discussion of the encounter is, who constructs irregularity? Who is involved in the encounter? Landolt and Goldring (2013:3) offer insight here through their work on precarious status noncitizenship<sup>23</sup>. For them, the precariousness of noncitizenship emerges through the encounters between precarious status noncitizens (such as refugee claimants) and service providers (ibid:15). Defining these encounters is conditionality work, which entails state-imposed conditions and the ability of actors to uphold or challenge them (ibid.). Their work alerts us to the various outcomes that can emerge through the encounter, and essentially, to the various ways that (non)citizenship is modified. As Hepworth (2014:2) argues, (non)citizenship is “modulated in the everyday to constitute a range of legitimately and illegitimately present non-citizen subjects”, regardless of legal status. Like borderwork (Rumford 2008; see chapter 3), the encounter alerts us to the role of everyday people, such as service providers (see Landolt and Goldring 2013), in the construction of (non)citizenship. The discussion of the encounter alludes to the important roles of

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<sup>23</sup> Precarious noncitizenship refers to those individuals who have “authorized and unauthorized forms of non-citizenship”, such as temporary foreign workers, refugee claimants, and international students (Goldring and Landolt 2013:3), and who lack “elements normally associated with permanent residence (and citizenship)”, including access to healthcare (14).

not only actors but also institutional policy, knowledges, state requirements, and other elements, in the construction of noncitizen others. For example, Bhuyan (2012) analyzes how service providers in Toronto's violence against women shelters navigate policy, funding, public opinion, and individual interpretations in the provision of services to nonstatus women, and ultimately, in decisions regarding who is eligible to receive access to these services. The relations between these elements, and the various positionings that emerge from them is reflective of the assemblage of irregularization which makes and re-makes irregularity in contradictory and unpredictable ways that restrict access to services.

In light of this conceptual overview of citizenship, I approach citizenship as a dynamic assemblage consisting of actors, encounters, laws, policies, procedures, knowledges and interpretations, etc., that problematizes presence and confers irregularity, resulting in contradictory, inconsistent, and unpredictable access to rights and services and experiences of anxiety and insecurity. This approach to citizenship as an irregularizing assemblage builds upon Landolt and Goldring's (2015) approach to (non)citizenship as constantly under construction, and complements McNevin's (2011:15-16) argument that abnormality is part of the history of citizenship and the production of "citizenship's outsiders".

Assemblage is an important term here. It not only allows me to consider how regulation operates and is experienced, but also how resistance emerges. As Ilcan (2013) argues, assemblages entail frictions and failures that can produce contestation. Furthermore, to approach irregular status as a type of subjectification process that emerges through citizenship yields the conceptual space to attend to the production of political subjectivities, because, as Butler (1994:163) argues, "to claim that the subject is constituted is not to claim that it is determined; on the contrary, the constituted character of the subject is the very precondition of its agency". I

analyze such struggles and political subjectivities through the concept of acts of liberating irregularity.

### **Resisting the Irregularity of Noncitizenship through Acts of Liberating Irregularity**

Acts of liberating irregularity can be defined as deeds or conducts that aim to free persons/groups from irregularity. These acts are performed in visible and less visible (Ataç et al. 2015:6-7) ways through solidarity, and entail assertions of presence and a right to be free from the discrimination that constitutes irregularization. In other words, acts of liberating irregularity challenge the criteria of presence and who can make claims within space. It is reminiscent of Johnson's (2015:958) concept of 're-taking presence', which is the "contest[ation] [of] citizenship as the necessary qualification for being 'here', and so for speaking and participating"; to re-take presence means to "relocat[e] a different subjectivity in presence, populating the 'space' of society with subjects that are in addition to the citizen". Building on this discussion of the emergence of the political subject through re-taking or asserting presence, I argue that the political subject that emerges through acts of liberating irregularity are 'common' subjects (see Casas-Cortés et al. 2014a:457). In this chapter, I demonstrate how allies enact themselves as such subjects who create 'common' spaces (see Anderson et al. 2009, 2012; Chapter 2) and also resubjectify refugee claimants as commoners. Such a focus highlights the importance of solidarity in analyses of resistance.

To emphasize the importance of solidarity within acts of liberating irregularity complements current discussions of 'acts' and the political subject. Acts are defined as "those constitutive moments, performances, enactments and events when a new identity [...] is brought into existence", and "when something, however small and seemingly marginal, is changed,

possibly for the first time” (Walters 2008:192). Here, Walters argues that acts draw attention to the importance of moments that bring about beginnings and new identities; it represents a shift away from a focus on the acting subject to the act itself. The new identity that emerges through the act—being the political subject—can, according to Nyers (2011:8), come from both “usual and unusual subjects, expected and unexpected voices, and obvious and not so obvious places, spaces, and temporalities”. While this statement may be employed to support the argument that precarious status noncitizens, or persons on the margins, can enact themselves as political subjects, I argue that it can also be employed to reassert the fact that citizens too enact themselves as political subjects. In other words, it is possible to look at those political moments and subjectivities that emerge not simply amongst those who have ‘no part’ but also those who have a part, or those who are part of, such as the citizen. Castañeda (2013:228) offers such an analysis. She argues that efforts by doctors (i.e. citizens) to provide medical aid to unauthorized migrants in Germany disrupts ideas of citizenship and can therefore be thought of as acts against citizenship; these actors enacted themselves as ‘activist’ citizens who were “answerable to justice against injustice” and who called the law into question (and broke it) (ibid:237). Here, citizens play an important role in challenging the irregularizing effects of (non)citizenship. Furthermore, their involvement is rendered all the more important once securitized state contexts are taken into account; for many irregularized groups, such contexts make acts quite risky (Castañeda 2013; Pasquetti 2015). It is in this light that I focus on citizen allies (i.e. healthcare professionals) in my analysis of acts of liberating irregularity in this chapter.

Acts of liberating irregularity build upon critical migration and citizenship scholarship which analyze moments of being political or ‘acts of citizenship’ (Isin 2002, 2008). Isin’s (2002:2) framing of citizenship as entailing relations of power means we can understand

citizenship as constituted by struggle in ways that shape the content and extent of citizenship. As Foucault (1982:790) argues, “at the very heart of the power relationship, and constantly provoking it, are the recalcitrance of the will and the intransigence of freedom”. Because power is exercised over free subjects, it is “freedom’s refusal to submit” which incites struggle (ibid). Such struggle is usually directed at the subject positions that have been accorded to us (Foucault 1982), therefore in the case of citizenship, it is the ‘other’ subjectivity or irregular status that individuals challenge. As Isin (2002) argues, citizenship involves moments of ‘becoming political’, when strangers, outsiders, and aliens enact themselves as “different from the dominant image given to them” (33) by questioning and contesting constructed “categories, classifications, and identities” of otherness (4). To become political then is to call into question “the naturalness of the dominant virtues” and reveal their arbitrariness (ibid:275). This is perhaps made explicit through the concept of ‘acts of citizenship’, which are “those acts when, regardless of status and substance, subjects constitute themselves as citizens or, better still, as those to whom the right to have rights is due” (Isin and Neilson 2008:2). Through this concept, scholars have drawn attention to, for example, how: non-status Algerian refugees in Montreal self-organized to end deportation and to regularize their status (Nyers 2010); Eritrean refugees in Israel publicized their presence as rightful refugees through demonstrations and the issuance of ID cards (Müller 2016); intergenerational migrant youth resisted the space of citizenship through vernacular music and language, which challenges narrow national linguistic and ethnic ideologies (Ní Mhurchú 2016); and how a group of undocumented migrants in Brussels invoked a radical equality and enacted themselves as citizens by working alongside and feeding refugees and citizens through a fixed kitchen within an informal refugee camp (Depraetere and Oosterlynck 2017). While acts of liberating irregularity is built upon acts of citizenship, it also moves beyond it.

Acts of liberating irregularity speaks to an emerging call to attend to everyday less visible acts (Ataç et al. 2015) and ‘moments’, as well as solidarity (Johnson 2012:123), in analyses of resistance. Johnson (2012:123) claims that while ‘moments’ may not overtly challenge systemic practices, they can establish noncitizens as rights bearing subjects who can create progressive change in their everyday life, making moments worthy of attention. Focusing on less visible acts attempts to keep in mind the vulnerability and violence of living with precarious status noncitizenship, which can lead to detention or deportation ; these practices reaffirm the boundaries of membership and belonging by dividing citizens from strangers (Anderson et al. 2011). Ilcan et al. (2017) speak to the precariousness of noncitizenship through their concept of the ‘ambiguous architecture of precarity’, which is comprised of precarity of status, space, and movement, alerting us to the various forms that precarity can take. Acts of liberating irregularity focuses on both visible and less visible acts, which aims to draw attention to not only the importance of the latter in the establishment of political moments, but also because of the riskiness of securitized national and transnational migratory contexts.

Acts of liberating irregularity also complements emerging calls to shift away from citizenship as an analytic. Scholars argue acts of citizenship may reinforce the exclusionary identity and practice of citizenship by representing demands and claims by noncitizens as appeals to and for citizenship (Johnson 2015; Landolt and Goldring 2015; Papadopoulos and Tsianos 2013; Tambakaki 2015); as Hindess (2004:307-308) and Sharma (2005:11) remind us, citizenship is far from being a progressive force and has not always been the preferred option throughout history and even today. Tonkiss and Bloom (2015:840-843) and Johnson (2015:957) argue that analyzing the claims of noncitizens as claims to and for citizenship may render scholars less able to understand the politics emerging within noncitizen protest. Acts of liberating

irregularity complements this emerging critique by focusing instead on claims founded on presence. Building on this conceptual framework of citizenship as an irregularizing assemblage, I offer below an empirical analysis of the IFHP during the tumultuous time of the IFHP cuts—from June 2012 to April 2016—within the context of Toronto’s everyday healthcare places. However, I first offer an overview of the IFHP.

### **The Interim Federal Health Program (IFHP)**

Citizens and permanent residents of Canada have two options for healthcare coverage: public insurance, which is government administered; or private insurance, which is provided through an employer or university, or paid for individually. In the province of Ontario, public insurance is offered through the Ontario Health Insurance Plan (OHIP). Those people eligible for OHIP are Canadian citizens, Indigenous persons, permanent residents, people working full-time with a valid work permit for at least six months, those who have a valid work permit under the Caregiver Program or Seasonal Agricultural Worker Program, convention refugees or other protected persons, or people with certain types of temporary resident permits<sup>24</sup> (Province of Ontario 2017). The experience of noncitizens in accessing Canadian healthcare coverage varies. While a wealthy noncitizen businessperson may not be eligible for OHIP, they will more than likely be able to afford private health insurance or have access to coverage through their place of employment. International students, while not eligible for OHIP, receive private insurance through their academic institution. In the case of refugee claimants, they are not eligible for OHIP<sup>25</sup>, nor are they likely to be able to afford private health insurance. As a result, the federal

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<sup>24</sup> This does not include refugee claimants (Government of Canada 2017a).

<sup>25</sup> Prior to March 31, 1994, refugee claimants residing in Ontario were covered through OHIP. However, Ontario altered the eligibility rules to deny coverage to temporary residents, such as

government provides health insurance for this population through the Interim Federal Health Program (IFHP).

Introduced through a 1957 Order-in-Council, the IFHP provides refugee populations (refugee claimants, protected persons, and resettled refugees) with limited, temporary healthcare coverage. The IFHP provides basic healthcare coverage, coverage for preventative and supplementary care, and prescription drug coverage, as well as certain dental procedures, limited eye care, immunization, and prenatal and obstetrical care to all recipients; this is similar to what permanent residents and citizens on social assistance receive. Refugee claimants receive IFHP coverage once their claim is deemed eligible to be heard by the Immigration and Refugee Board (IRB), and it lasts until they are eligible to receive provincial healthcare coverage or can afford private health insurance. By 2012, it is estimated the program covered 128,586 persons (Canadian Doctors for Refugee Care, et al. v. Canada 2014:17), at an estimated cost of \$83 million per year (Dhand and Diab 2015:358). Due to financial costs and an increasingly securitized environment that sought to regulate the movements of certain noncitizens, amendments were made to the IFHP in 2012.

On 5 April 2012, the federal government passed an Order-in-Council (P.C. 2012-433, the *Order Respecting the Interim Federal Health Program, 2012*) that repealed and replaced the original 1957 Order-in-Council with a much more restrictive program without consultation from important stakeholders; it came into effect on 30 June 2012. The revised program restricted healthcare coverage for refugee claimants in a tiered manner. Specifically, it introduced three different types of healthcare coverage: expanded healthcare coverage, healthcare coverage, and

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refugee claimants, meaning refugee claimants had to rely solely on the much less comprehensive IFH program (Sansom 1997:202-203).



public health and public safety (PHPS) coverage. Refugee claimants from a non-designated country of origin<sup>26</sup> (DCO) received healthcare coverage, which included coverage for urgent and essential medical services, limited lab and diagnostic services, and no prescription coverage except to prevent or treat a PHPS threat. The most restrictive coverage, PHPS coverage, was provided to DCO claimants and failed claimants who received no coverage for services or medications unless to prevent or treat a PHPS threat (CCR 2013a). This meant that life-sustaining medications like insulin were no longer provided. These restrictions applied even to pregnant women and children (CARL 2013).

The IFHP cuts were an attempt to protect the Canadian public, and Canada's refugee system and healthcare resources, from 'bogus' refugees. According to Immigration Minister Jason Kenney:

Canadians are a very generous people and Canada has a generous immigration system [...] However, we do not want to ask Canadians to pay for benefits for protected persons and refugee claimants that are more generous than what they are entitled to themselves. [...] With this reform, we are also taking away an incentive from people who may be considering filing an unfounded refugee claim in Canada [...] These reforms allow us to protect public health and safety, ensure that tax dollars are spent wisely and defend the integrity of our immigration system all at the same time (Fitzpatrick 2012).

In this statement, Minister Kenney emphasizes how the generosity of Canadians and the Canadian system are under attack from refugee claimants. Here, the use of generosity can be understood as Canadianness, which for Baines and Sharma (2002:85), is "inextricably joined" to "the operation of citizenship in Canada". According to Sharma (2001) ideas of Canadianness, such as being just, accepting, and tolerant, constructs 'others', justifies the denial of rights and

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<sup>26</sup> Designated Countries of Origin (DCO) are deemed 'safe' countries by the Canadian government; they "do not normally produce refugees, but do respect human rights and offer state protection" (Government of Canada, 2017b). There are currently 42 countries listed.

entitlements to ‘others’, and provides the space to imagine their other-than-Canadian characteristics. Refugee claimants are constructed as the opposite of Canadianness—disingenuous, selfish, and threatening—which warrants a response to be not generous to those who take advantage of ‘our’ generosity. Anderson (2017:8, 19) also alerts us to how ‘others’ tend to be imagined as ‘invasive insects’, which transforms migrants (and refugees) into masses who will consume finite resources through their numbers, and ultimately into persons whose lives “do not matter”. This image was arguably employed by politicians during the time of the IFHP cuts. Helleiner (2012:112) expands the discussion of Canadianness as also structured by a “hegemonic white Canadian nationalism” that “position[s] nonwhites as ‘negative disruptions of the Canadian landscape’”, as outsiders, and as targets of surveillance. Interestingly, in 2012, the same year as the IFHP cuts, the large majority of persons claiming asylum in Canada<sup>27</sup> were racialized populations, which makes Helleiner’s claim quite significant, and alerts us to the importance of Sharma’s (2015:98) argument that “racism is central to the construction of the ‘others’ of citizenship” and to claims of belonging<sup>28</sup>. In addition to Canadianness, state citizenship also played a part in the cuts.

Kenney’s quote also draws on state citizenship, in that, as members of the Canadian nation-state, Canadians have a legitimate claim to receive better healthcare over ‘others’ (Sharma 2012:33). For Sharma (2012:28), such violent nationalist sentiments continue to be seen as unproblematic in the grand scheme of discrimination, inequality, and the “stratification of social formations”. The entitlement to healthcare is founded on the idea of legitimacy of presence

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<sup>27</sup> The top ten originating countries were Mexico, Hungary, China, Haiti, Nigeria, Colombia, Saint Vincent, Sri Lanka, Namibia, and Pakistan (CCR 2013b).

<sup>28</sup> Sharma (2015:98-99) argues “it is because the ‘nation’ is imagined as composed of particular ‘races’ of people [...] that *together* racism and nationalism have—and continue to—define the boundaries of national citizenship”.

within the state, which is itself founded on citizenship status (Johnson 2015:958). According to Sharma (2001:431), legitimacy “is secured by enshrining the rights of those who are placed (and have placed themselves) within categories that privilege them in relation to Others who are placed within far more inferior categories”. In other words, one’s Canadian status deems one to be more entitled to services than ‘others’. The cuts to the IFHP were framed in a manner that legitimized the state’s responsibility to protect its citizens and affirmed the importance of citizenship as a virtuous position within the state. Through Canadianness and Canadian identity, the refugee claimant was constructed as other, which allowed for imaginations of this population and their characteristics, as well as justifications for unequal treatment. As an Executive Director of a Community Health Center states: “I think [the IFHP] reinforced the sense of some people being more deserving than others” (Interview with Executive Director, Toronto, 11 November 2015). Through citizenship, the irregularity of the presence of refugee claimants was affirmed.

Various politicians assisted in the construction of the refugee claimant as irregular ‘other’ through government speeches, flyers, petitions, and surveys (Bolen 2012a, 2012b; CBC News 2015), which significantly shaped how everyday actors encountered refugee claimants. According to a policy analyst: “people who continued to have IFH coverage could be refused care, and it was partly because [...] there was so much political rhetoric around bogus refugees who were being made ineligible for care” (Interview with Policy Analyst, Toronto, 21 October 2015). The construction of refugee claimants as bogus, and as threats to Canadian healthcare and refugee systems, within various forms of media shaped how everyday actors imagined and encountered this population as ‘ineligible’ for care. A doctor elaborates,

a lot of healthcare providers thought [refugee claimants] didn’t have coverage anymore when in fact they did for most medical things. They did lose coverage for example for drugs and for physiotherapy, dental, vision, but for medical things, most people were still covered. However, they were being told, even

refugee claimants were being told by their social workers, by their settlement workers, that their IFH paper is garbage. That it's useless, they're not covered (Interview with Doctor, Toronto, 20 October 2015).

This example alerts us to not only media and politicians in the construction of irregularity, but also the limited and confusing information provided to service providers about the program (Interview with Doctors, Toronto, 20 October 2015 and 10 November 2015). Interestingly, due to the little information that was shared with professionals, they came to rely on the media to gain access to information about the program, which only exacerbated the issue. This complements Villegas' (2015a:233) argument that the knowledges of everyday actors, which are based on policy, media, and conversations, threaten the safety of precarious status noncitizens and their ability to access social goods.

A *Charter* challenge was launched against the federal government by the Canadian Doctors for Refugee Care (CDRC), the Canadian Association of Refugee Lawyers (CARL), Justice for Children and Youth (JFCY), and two refugee claimants, Daniel Garcia Rodriguez and Hanif Ayubi. They requested a judicial review of the federal government's decision to reduce coverage, claiming the cuts were inconsistent with Canada's international obligations to refugees and in violation of Section 7 (the right to life and security of the person), Section 12 (cruel and unusual treatment), and Section 15 (discrimination) of the *Canadian Charter of Rights and Freedoms* (CARL 2013). On 4 July 2014, the Court ruled the cuts were in violation of Sections 12 and 15 of the *Charter*. The government was ordered to introduce a revised program within a four-month timeline, and although the federal government appealed this decision, they introduced, on 4 November 2014, the 'temporary' IFHP, reflecting their desire to re-instate the 2012 program.

The ‘temporary’ IFHP restored benefits to pregnant women and children, and provided to all refugee claimants regardless of country of origin coverage for medical, diagnostics, hospital services, and medications for PHPS threats (Government of Canada, website). However, this victory was short-lived because the new revisions to the program added more confusion to an already complex program through the introduction of six types of healthcare coverage, with refugee claimants receiving ‘type three’ coverage. As a result, the presence of refugee claimants within the space of the healthcare centre was further problematized as “bodies ‘out-of-place’” (Hepworth 2014:7). Below, I offer an empirical analysis of Toronto’s everyday healthcare places to gain a better appreciation of the irregularizing assemblage of citizenship.

### **The Irregularity of Noncitizenship in Toronto’s Everyday Healthcare Places**

For many refugee claimants, the irregularity they experienced within Toronto’s everyday healthcare places was shaped by the comparison between OHIP and the IFHP. Prior to the 2012 changes, all IFHP recipients received the same type of coverage, which not only allowed doctors to more easily navigate the program, but it also made the program more acceptable and normal within the healthcare space. According to a doctor,

as long as someone had a valid IFH certificate, you didn’t have to know if they were government assisted, or privately sponsored, or a claimant, or they were from this country, or they had their hearing, or they’re filing a federal court review, and that became irrelevant. It became just like having an OHIP card in many ways (Interview with Doctor, Toronto, 19 October 2015).

As this doctor notes, the IFHP was more acceptable prior to the cuts because it was ‘just like’ OHIP, meaning IFHP recipients were also more accepted and considered to be much less problematic. However, the program has always been fundamentally different from OHIP, which is evident not only in its visible appearance (see chapter 3) but also through the bureaucracy issues, payment delays, pre-approval processes, and lower financial compensation (CHA 2012,

McKeary and Newbold 2010) that define it. As one doctor states, the “IFH was always a bit of an issue because it’s not OHIP right?” (Interview with Doctor, Toronto, 20 October 2015). The fact that the IFHP is not OHIP can create confusion among many frontline workers and as a result, it can lead to rejection. A social worker elaborates on this issue:

I remember having clients in 2010 who would say “I tried to go to the doctor and they didn’t understand what IFH was” [...], and I remember having to explain it to a secretary, like a medical secretary [...] and they were like “Can you fill out the form?” And I was like “No, I’m not the medical provider, I’m a social worker. They won’t take the form from me, it has to be you!” So even before the changes there was sometimes a lot of resistance from private physicians in providing services to refugee claimants because they didn’t want to deal I think with IFH (Interview with Social Worker, Toronto, 26 November 2015).

Here, the IFHP is discussed as the other of OHIP; its irregularity, which is constructed in relation to OHIP, can at any time work to problematize IFHP recipients. In this light, the irregularity of refugee claimants is constructed through their enrolment in and membership of the IFHP (see Isin 2002:ix). Through this enrolment and membership, refugee claimants are accorded a status that is different from the citizen with the OHIP card, and they are effectively rendered less able to make a claim for access to healthcare services. In this regard, the IFHP document solidifies the equation of citizenship (i.e. OHIP) with presence and legitimacy within the healthcare setting.

These encounters between medical professionals/personnel and refugee claimants carry traces of power relations, whereby the former group has more power than the latter group to determine who is ‘out of place’ (Hepworth 2014:7). While the irregular status that emerges here is shaped by state policies, institutional practices, and individual knowledges and understandings, it is also affected by place. The place of the healthcare setting is imbued with power relations, verification mechanisms, and expert knowledge that lend to practices of identification and classification (see chapter 3). Place determines how bodies come together and how bodies are identified as out of place, such as race, how the body is clothed (Hepworth 2014:8), or in this

case, how refugee claimants are insured. The confluence of these elements not only shape ideas of noncitizenship and irregularity but (re)define and (re)constitute subjects as such, regardless of legal status or healthcare coverage. As a result, one's ability to gain access to services is impacted. While Landolt and Goldring (2013) and Hepworth (2014) argue the encounter is an important medium in which to analyze the (re)construction and (re)articulation of (non)citizenship in the everyday, Isin (2002:34) also notes the importance of encounters in the production of discrimination; the imaginations that emerge through the encounter tend to entail the worst characteristics or attributes of citizens, which generate stereotypes and illustrate how restrictions to services and resources are justified.

While discrimination is evident in the targeted denial of services to IFHP recipients (Interview with Doctor, Toronto, 20 October 2015), discrimination also emerges within everyday healthcare places. Here, discrimination can include religious or cultural insensitivity, unfriendly behaviour, "racial slurs, stereotyping, and receipt of inferior care" (Pollock et al. 2012:63). In their work on healthcare access among migrant and refugee populations in Toronto, Campbell et al. (2014:172) point to the importance of language, as noted by one of their participants: "when they identify you as an immigrant, and you can't speak the English language, you can immediately see the discrimination". Language emerged as an important element in my research, specifically, how limited English language skills can impact personal health. Cases exist of refugee claimants seeking out healthcare services only to be met with restrictions because of their lack of English language skills. For example, a refugee claimant describes how his roommate, who has limited English language proficiency, is denied access to a translator:

They [the doctors] have not provide him a translator [...]. If he don't understand you, you don't understand him, how will you give the tablets or pills to him? He said they never provide him a translator. That's a mistake. [...] You know, he's telling his problem but we don't understand what's the problem. [...] If we are

living with him, we can't understand, how doctor will understand? How he will understand the doctor? That is a big problem (Interview with Refugee Claimant, Toronto, 11 March 2016).

The important point in this quote is “that’s a mistake”. This refugee claimant makes this statement because of his certainty of always being able to have access to a translator. The Toronto Central Local Health Integration Network (TC LHIN)<sup>29</sup>, which consists of over 170 health service providers, created the *Language Services Toronto* program, which is an over-the-phone medical interpretation service offered to patients in hospitals, community health centres, family health teams, and other community health agencies (Centre for Research on Inner City Health 2014). Considering these refugee claimants reside in the TC LHIN catchment area, and therefore utilize the services of its healthcare providers, one may raise questions about discrimination in this participant’s case, however whether or not this lack of access to language translation is intentional is uncertain.

Although language is important, lack of OHIP is perhaps the most prominent element in experiences of discrimination. As a refugee claimant explains, “I can feel the discrimination when I pull out my papers. I don’t have OHIP. The receptionist’s face will take on a look of disdain. I get worse treatment than the Canadians who have the right card” (Campbell et al. 2014:172). A midwife elaborates,

I feel like there is that kind of prejudice where somebody assumes like, oh she doesn’t have OHIP, she’s not going to be able to pay, she’s here illegally, or without status. So I think that’s a lot of like social barriers [and] racism that people encounter in these situations (Interview with Midwife, Toronto, 22 January 2016).

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<sup>29</sup> The TC LHIN is located in the core of the City of Toronto, and extends to Scarborough, North York and Etobicoke.



Some of these barriers also emerge in the hospital setting which can seriously impact one's health. According to a Program Manager:

under the law, hospitals are actually not allowed to turn people away in an emergency, but I have had incidence of hospitals trying to convince people that it's not an emergency in order to get them to go away (Interview with Program Manager, Toronto, 8 October 2015).

The emerging ideas from encounters with refugee claimants who do not have the 'right card' include difference and illegality and result in denial, disdain, avoidance, neglect, and deceit. The fact that the IFHP is not the 'right' document leads to the problematization of the presence of refugee claimants within space, and the attribution of irregularity, which facilitates imaginations of the irregular other. A refugee claimant shares their experience of discrimination in a nearby walk-in clinic:

I need a family doctor because the walk-in clinic that I used to go, they don't take care of me very well. The first that I went, the doctor that tend to me was very good on me. So, the second time I went, he was not around, I went to another doctor, and was so harsh on me (Interview with Refugee Claimant, Toronto, 11 March 2017).

This harshness is in fact neglect; their concern regarding the effects of a prescribed medication was met with indifference by the doctor. Other cases of discrimination exist, including when a pregnant woman faced discrimination in a hospital because of her country origin listed on her IFHP document (Marwah 2014; see chapter 3); even though she was a legal authorized temporary resident with full coverage, her noncitizenship was modulated in irregularizing ways (see Hepworth 2014:2). However, Isin (2002:4-6) reminds to be aware of the struggles that constitute citizenship and of the resistances that emerge from its subjectifications and arguably irregularizations. I therefore detail how irregularization/irregularity is challenged through acts of liberating irregularity.

## **Acts of Liberating Irregularity**

In my approach to the IFHP, I am influenced by Fassin's (2012:136) argument regarding a recent shift in migration policies, from a logic of legal differentiation to legitimate discrimination; the changes made to the IFHP reflect this shift towards legitimate discrimination. Viewing the IFHP in this manner informs my approach to acts of liberating irregularity. These are not claims to or for legal citizenship status, rather they are claims that assert presence and a right to be free from discrimination. Below, I offer some examples of acts of liberating irregularity, and I understand them as such due to their ability to make a difference (Isin 2002). In this chapter, I focus specifically on those acts enacted by allies to demonstrate the importance of solidarity (Johnson 2012, 2014) specifically within state contexts that target precarious status noncitizens, such as refugee claimants (Landolt and Goldring 2015:854; Nyers 2003:1086-1087). For example, consider the following statement from a Program Manager:

when I was putting together one of our campaigns a few years ago, and I approached somebody who—I knew their family—was a refugee from Sri Lanka, he laughed, and he said [...] my family members won't come. They think the government will come after them and take away their status in Canada (Interview with Program Manager, Toronto, 7 October 2015).

Scholars also note such fears in their research. For example, Pasquetti (2015:709-10) analyzes how urban Palestinian refugees are less likely to organize due to a fear of state scrutiny and monitoring, while Basok and Carasco (2010:345) note how Canada's seasonal agricultural workers, "are often not in the position to claim rights", not only "due to the vulnerability of their status", but also their "unfamiliarity with the legal framework, and linguistic barriers". For many precarious status noncitizens, solidarity is essential in establishing access to rights and services. It is in this light that I emphasize the importance of allies in acts of liberating irregularity.

As discussed in the conceptual framework, I approach acts of liberating irregularity as entailing the enactment of self as a political subject. I define this political subject as the common subject, who challenges the enclosure of space, and the suffering and inequality that constitutes citizenship (and borders), and asserts the presence of irregularized persons. This is similar to Isin's (2009:379-383) concept of the 'activist' citizen who ruptures and rewrites scripts, routines, and understandings. Common subjects are engaged in commoning, which is the realization of political, social, and economic rights of commoners, and the prioritization of mutuality, inclusion, and equity (Anderson et al 2009:12). In the context of healthcare, the common subject acknowledges the rights of commoners to healthcare, which is based upon the above elements of mutuality, inclusion, and equity. Consider, for example, the following:

there should be no difference in healthcare whether you're undocumented or a claimant or whatever it is, it shouldn't matter. [...] We're all living together in this place whether you're the undocumented person who's underground or a citizen. We're occupying the same space, right? [...] It makes sense in terms of community health, in terms of equity, in terms of justice (Interview with Social Worker, Toronto, 26 November 2015).

This assertion of presence and rejection of difference and discrimination highlights how we can imagine the common subject within Toronto's everyday places. As I demonstrate below, the solidarity and performativity that constitutes acts of liberating irregularity play an important role in challenging the boundaries of belonging and rights. This is evident in policy and everyday places.

### Visible Acts: Policy

The Ontario Temporary Health Program (OTHP) was introduced on 1 January 2014 by the Ontario Ministry of Health and Long-Term Care (MOHLTC), in collaboration with prominent refugee allies, to 'top up' the coverage that refugee claimants lost through the IFHP cuts.

Discussed as a very “slick” program (Interview with Doctor, Toronto, 19 October 2015), OTHP represented a challenge to the state’s prerogative to distinguish between citizen and noncitizen subjects and to the forms of regulation that accompany this subjectification. According to a doctor involved in the development of OTHP:

We know it angered the [Immigration] Minister [Chris Alexander] when it was first announced, to the point where he made his first public statement on the IFH cuts only when OTHP rolled out, and he condemned the provincial government here in Ontario for attracting bogus refugees (Interview with Doctor, Toronto, 19 October 2015; see Mas 2014).

The actors involved in the development of OTHP acknowledged the injustice of restricting/denying healthcare coverage based upon constructed notions of irregularity. Through OTHP, they directly challenged the federal government to “live up to its responsibilities to provide health coverage for all refugee claimants” (Province of Ontario 2013). As a result, these actors called for the state to acknowledge the presence of refugee claimants and to provide this population with the rights they deserve.

However, OTHP was plagued with problems, such as a three-month wait period<sup>30</sup>, limited knowledge of the program, and a complicated administrative process (Interview with Doctors, Toronto, 19 October and 10 November 2015). According to a doctor, these complications were a result of the unwillingness of the federal government to allow this program to work effectively:

[OTHP] hasn’t worked very well for one simple reason. It’s because, I would suggest, the federal government has completely sabotaged the program, and how did they do that? They did that by not sharing information with the province. So now that information that goes to the federal person [at] that BlueCross office in New Brunswick, instead of them passing it down the hall if they can’t deal with it, they send it back to the clinician. The clinician has to then gather all the paperwork together and send it back to that same office at BlueCross in New Brunswick. And for many clinicians, [...] it’s time consuming, it’s

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<sup>30</sup> This did not apply to children, pregnant women, or people with life-threatening conditions.

bureaucratically very cumbersome to keep all that paper work around [...] and so OTHP hasn't really caught on as much as it should have (Interview with Doctor, Toronto, 19 October 2015).

Here, we can see how 'sovereign retakings' (Nyers 2003:1086-1087) are not only directed at marginalized 'others' with irregular statuses, but also towards allies; in their attempts to reassert the rights of refugee claimants, allies faced retribution from the state, not only by public scolding, as mentioned above, but also through bureaucratic red tape. As a result, the program was seen as an unattractive alternative, meaning many refugee claimants were not given the opportunity to access this coverage (Interview with Doctor, Toronto, 19 October 2015). For others, because they were simply unaware of OTHP, they could not offer access to it; this was quite prevalent in my interviews with participants. But perhaps what is most interesting about OTHP is that it only further irregularized refugee claimants. The program differentiated and discriminated against refugee claimants by introducing a separate program from OHIP. However, the importance of OTHP should not be underestimated because it reflects a form of disobedience and unexpectedness that delegitimized state efforts of control by acknowledging the presence of refugee claimants and other un(der)insured populations and effectively shifting the location of power to the province. A Program Manager speaks to this issue:

I think the City and the Province both operate based on a different narrative [than the state] because I think they have a much more long term perspective of these people [...], like let's say we end up with a number of non-status people, they still live in the city, they contribute to the well-being of the city, and if they don't do well it's the city that's going to end up paying for it, [...] so I think the City and the Province are very supportive of newcomers of all stripes (Interview with Program Manager, Toronto, 8 October 2015).

Here, the City and Province are seen as key actors who challenge the state's sovereign duty to distinguish and differentiate between persons, as well as key sites of refugee policy-making, which is largely a state activity. In this regard, the City and Province can be seen as engaging in

forms of municipal and provincial foreign policy that ‘reorients’ politics, transforms ideas of membership and rights, and constructs solidarities (see Nyers 2010:138). With the reinstatement of the IFHP on 1 April 2016, OTHP was discontinued 31 March 2016.

Through their efforts, allies used their citizenship to act against the irregularizing assemblage of citizenship. Through “a multitude of voices speaking together in the same message, demand or refusal” (Johnson 2014:197), allies enacted themselves as common subjects by attempting to open up space and resources for those present within the province. They can be seen as engaging in a type of re-taking presence by undermining “citizenship as the necessary qualification for being ‘here’” (Johnson 2015:958) and for gaining access to essential healthcare services. In this regard, OTHP arguably represents a critical reflection of the privileges and practices associated with Canadian citizenship and a type of commoning by sharing healthcare resources with those present. In addition to policy, visible and less visible acts of liberating irregularity occurred throughout the city’s everyday places, such as refugee and homeless shelters, Crossroads Refugee Clinic, Uninsured Clinics, Community Health Centres (CHCs), and by midwives.

#### In/Visible Acts: Places

Doctors from Toronto’s Inner City Health Associates (ICHA) offer primary care and psychiatric services to residents of drop-in centres, homeless shelters, and refugee shelters; for example, doctors from ICHA visit one refugee shelter’s small ad-hoc basement clinic twice a week for four-hour long sessions (Interview with Executive Director, Toronto, 20 October 2015). ICHA covers the costs of x-rays, ultrasounds, and may also cover the cost of blood work and medications (Interview with Doctor, Toronto, 20 October 2015). But these services are not

provided everywhere and depend very much on chance or word of mouth (see chapter 3). For example, according to a refugee claimant:

because I was from [Seaton House], first started, they provide me service from a family doctor. They are giving me service now, until now. But if I directly came here [to this refugee shelter], then it was a problem for me. There is no service. I have to pay from my pocket. Money I have not, then it's extremely a problem for me. Therefore we want service for every shelter [...] I am working with the same doctor that provide me from downtown, from [Seaton House]. She is a nice lady. Nice doctor. I like them, it is good for me. [...] But if I come directly here, [to this refugee shelter], they can't provide the service. That's a problem (Interview with Refugee Claimant, Toronto, 11 March 2015).

For this individual, their connection to Seaton House (a homeless shelter in downtown Toronto) allowed them to receive primary care services, including medication for diabetes. However, they also speak of the fortuity of this access, something which is noted by a social worker:

if somebody is a refugee claimant and they're new, they're often first living in a shelter. So, if the shelter connects them then it's great and there's some shelters [...] [who] have a nurse practitioner or they have a doctor because those doctors and nurse practitioners go into the shelter. They'll be there once a week and so then, even when the client moves out of the shelter, that remains their doctor for a couple of years [...] But sometimes that doesn't happen (Interview with Social Worker, Toronto, 26 November 2015).

For those refugee claimants who happen to access such medical services, such as the refugee claimant above, there are still experiences of insecurity, specifically with regards to access to medication. They elaborate:

First when we start my medicine for diabetes and high blood pressure, the doctor asked me which tablets you are taking back home. I told them, then he [...] said these tablets, these pills, are very costly. We can't get them. [...] They tell, we are paying, and that this is very costly, we can't provide these pills to you, we will give other pills that will control your diabetes but slowly. [...] Then they are giving me the other pills till now. [...] At my home, I was taking only one pill in the morning for diabetes, but here, two in the morning, two in the evening. Four pills I am taking for diabetes. That is a problem (Interview with Refugee Claimants, Toronto, 11 March 2017).

The above quotes reflect well Villegas' (2013b:221) argument regarding the "insecure and negotiated quality of access to health care" among Canada's precarious status noncitizens. These participants emphasize chance as one of the key determining factors in gaining access to healthcare and patchiness as the outcome of these connections. This type of precarious access to healthcare reflects Ilcan et al.'s (2018) argument of how precarity is compounded by status, space, and movement to create vulnerabilities in everyday life; the outcome of the relation between status and space is made evident in the above cases.

In addition to shelters, refugee claimants and other un(der)insured populations can access free healthcare services at uninsured clinics such as the Canadian Centre for Refugee & Immigrant Healthcare (CCR IH), and the Scarborough Women Assessments and Needs (SWAN) Clinic located in Scarborough. Here, a voluntary team of healthcare professionals offer primary care, paediatric, dental, and chiropractic health services (CCR IH website). While uninsured clinics are arguably important healthcare actors in Toronto, specifically for vulnerable and marginalized populations, they are not reliable sources of healthcare. As a City official states:

It's just really hard to figure out where they are and how to access them and what services they provide and when they provide them, because even with the dedicated services [...] one of the barriers is that [...] they are not open every day of the week. Most of them are open like two afternoons or two evenings a week. So, if it's a Wednesday and this clinic's open Tuesday's and Thursday's, and that one is Monday's and Friday's, and that one is only Saturday afternoons, it can be really hard right? (Interview with City Official, Toronto, 6 October 2015).

The difficulty in finding the locations of uninsured clinics is due to the silence that tends to surround these places. As one doctor states, the provision of care is "a balance between wanting people to know they can seek services versus not declaring that we are providing services to people who are potentially nonstatus and ourselves being vulnerable to immigration enforcement" (Interview with doctor, Toronto, 20 October 2015). Drawing from Nyers' (2010:141) critique of Sanctuary City, the shelter and uninsured clinic services may similarly



“reproduce the logic of silence, [and] subterfuge” that already characterize the lives of precarious status noncitizens. Here, the complexity that defines attempts to liberate refugee claimants from irregularity is made evident because silence also works to avoid the gaze and ‘retakings’ of the state. Although issues of funding, reliability and quality of care define uninsured clinics (Interview with Nurse, Toronto, 16 October 2015), and shelter services, they are nevertheless important spaces in the overall struggle against irregularization and in the everyday lives of refugee claimants and other un(der)insured populations in Toronto. To elaborate, they may be seen as political spatial manifestations that re-appropriate space, subvert marginalization, acknowledge the presence of un(der)insured populations and their right to healthcare, and offer a common space that is founded on recognition and mutuality.

A more visible act of liberating irregularity occurs in Crossroads Clinic, Toronto’s first hospital-based refugee health clinic. Crossroads offers medical services to refugee claimants for their first two years in Toronto and connects patients with a family physician afterwards (Women’s College Hospital website). Doctors from this clinic also offer primary care services at Sojourn House, a refugee shelter in Toronto (Women’s College Hospital 2014). CHCs and midwives are also important actors. Funded by the MOHLTC, CHCs offer a range of free services to any resident of a specific catchment area, regardless of status, including primary care, housing support, counselling, physiotherapy, legal service connections, and group supports; these places may also offer free medications to patients<sup>31</sup> (Interview with Executive Director, Toronto, 11 November 2015). Also funded by MOHLTC, midwives offer pre- and post-partum services free of charge to pregnant residents of Ontario, regardless of status. In addition to birthing

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<sup>31</sup> Hanif Ayubi, a refugee claimant involved in the Charter challenge, received free medications through his local CHC.

services, midwives also assist clients by connecting them with CHCs (Interview with Midwife, Toronto, 22 January 2016).

These places and actors call injustice and irregularity into question by providing healthcare services to refugee claimants. They assert refugee claimants as commoners and as therefore having a right to not be distinguished from, or as, others (Anderson et al. 2012:85-86). These acts can perhaps be understood as representing a political resubjectification, in that the irregular status of refugee claimants is dismantled in favour of an identity of a common subject, being a subject who is present and has a right to make claims to healthcare. Such forms of political resubjectification is noted by Castañeda (2013) in her analysis of refugee healthcare in Germany. For her, the provision of care also represents “a powerful form of dissent” because it disrupts the role and meaning of citizenship by treating un(der)insured precarious status noncitizens as having a right to healthcare and a right to be present (ibid:228). Asserting presence undermines the constructed status of irregularity and aims to make healthcare oblivious to (non)citizenship. This is a type of cosmopolitan ethic which endorses “each individual everywhere and at any time [...] [as] an ultimate unit of equal moral concern” (Wild 2015:45). The above examples of policy and place alert us to the importance of solidarity in the creation of ruptures that expose the arbitrary foundations of inequity. However, I am also aware of the faults of solidarity.

Solidarity can transition into relations of speaking ‘for’ and not ‘with’, which can perpetuate marginalization, silence, and oppression. For example, in their attempts to humanize refugee claimants, allies utilized familiar images of voicelessness and powerlessness (see chapter 5). This underlying problem of solidarity was noted by the allies that I interviewed. For example, a doctor reflects on this contentious relationship:

one of the things we can easily be accused of is paternalism, speaking on behalf of people, but I'll stop there because [...] they couldn't. They were terrified. They didn't want to expose themselves to the state, and so, because they couldn't speak, we had to. There was [...] this leading American doctor who said that doctors had a duty to use their voices loudly and strongly to intervene on behalf—to intervene not only for justice and healthcare, but for justice in general which is affecting patients' health, [...] and that's exactly what we were doing the whole time (Interview with Doctor, Toronto, 10 November 2016).

It is this duty to protect that nullifies solidarity and instead imposes an unequal relationship that maintains the requirement of the citizen and expert to speak in order to be heard. While it is important to be aware of this fine line that constitutes solidarity, it is also important to be aware of those cases of solidarity that challenge irregularity with or alongside irregularized populations; this is seen in the provision of healthcare, system navigation, word of mouth, and protests, all of which position refugee claimants as 'here'.

### **Conclusion: How can we transgress irregularity?**

Drawing on critical citizenship scholarship (Isin 2002; Johnson 2012; Landolt and Goldring 2013; Sharma 2001), this chapter argued for an approach to citizenship as an irregularizing assemblage that problematizes the presence of persons/groups within space and positions them as 'out of place', abnormal, or otherwise irregular. Here, irregularity can be understood as a status that is produced in relation to citizenship, reflecting McNevin's (2011:15-16) argument that abnormality is part of the history of citizenship. But in addition to this analysis, I build upon the above scholarship through acts of liberating irregularity to draw attention to how irregularity is resisted and struggled against through solidarity. These acts assert presence and a right to be free from discrimination, and include enactments of political (re)subjectification, which I imagine to be the common subject. However, by focusing on these acts, this chapter illuminates the complexity and contradictions that define the politics of irregularization.

While the focus of this dissertation is on refugee claimants, I acknowledge that other marginalized populations in Toronto, and across the country, such as Indigenous and homeless populations, are also irregularized in ways that deny or restrict access to healthcare services; this is not only due to improper/inadequate documentation, but also Canada's history of colonization, and current notions of the proper neoliberal citizen (Khandor et al. 2011:99-100; Labby 2017; Purdon and Palleja 2018). These productions and experiences of irregularity or irregular status highlights the importance of an expanded conceptualization of irregularity (see Nyers 2011b).

I conclude this chapter with the question: how can we transgress the irregularizing assemblage of citizenship? Speaking specifically to my case study, perhaps the extension of OHIP coverage to all residents of Ontario would work to transgress irregularization by nullifying citizenship and effectively transforming all healthcare places into spaces of social justice. In fact, the provincial government is currently being pressured to extend OHIP to all residents of Ontario (Ohipforall.ca). However, for some scholars, something more fundamental must take place in order to create a true transformation towards social justice—that citizenship itself must cease to exist. As Schweppe and Sharma (2015:4) argue:

“Citizens” and their “migrant”-others go together: they are co-produced. Only by rejecting national citizenship as the basis of our connections to others [...] can we open up the possibility of reclaiming our planet from capitalists and states and taking it back as our collective source of life.

For Sharma (2012:46), “eschewing national styles of solidarity and antagonism” that citizenship constitutes and perpetuates would “make the global character of human (and other) relationships” reappear and would “activate new subjectivities” in ways that would affirm freedom, commonality, and equality. Although oftentimes subtle in their efforts and outcomes, the acts of liberating irregularity discussed in this chapter (and chapter 3) are contributing to this rejection. In the next chapter (chapter 5), I consider how the irregular status accorded to refugee

claimants is founded upon the humanitarian system that this population is implicated in and defined through. It is in this chapter that I also pay critical attention to the contradictions of acts of liberating irregularity and the affirmative politics of irregularization.

## Chapter 5<sup>32</sup>

### **In the Name of Humanitarianism: The IFHP and the (Affirmative) Politics of Irregularization**

It is by now well known that we are currently in the midst of the worst humanitarian crisis in history, with 65.6 million people forcibly displaced worldwide (UNHCR 2017). Included in this number are asylum seekers, also referred to as refugee claimants. According to the UNHCR, a refugee claimant is “someone whose request for sanctuary has yet to be processed” by a national asylum system; these systems “are in place to determine who qualifies for international protection” and who does not (UNHCR). Canada’s asylum system reflects the UN Convention Relating to the Status of Refugees, in that the country’s Immigration and Refugee Protection Act (IRPA) determines refugee eligibility based upon the definition of refugee offered in the Convention (Government of Canada 2018). To be determined a refugee by a national system means that persons have passed in-depth scrutinization regarding their fear of persecution. In contrast to the refugee who has proven their fear, refugee claimants have yet to prove this fear. It is this fundamental element of ‘yet to prove’ that renders the presence of refugee claimants within the state vulnerable to targeting and questioning.

In this chapter, I analyze how the presence of refugee claimants is problematized as a result of their implication within international and national humanitarian systems that offer refugee protection. I argue that national asylum systems work to position this population as irregular, in that they are positioned as not reflecting the norm and problematically present. Here, the norm is the accepted Convention ‘refugee’. I approach such humanitarian systems as

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<sup>32</sup> As part of my manuscript style dissertation, a version of this chapter was accepted for publication as: Connoy, L. (In Press) “In the Name of Humanitarianism: The IFHP and the Irregularization of Refugee Claimants”. *Refuge: Canada’s Journal on Refugees*.

irregularizing assemblages that situate refugee populations in hierarchical and unequal positions so as to determine who is legitimately deserving and worthy of protection and the relief of suffering. Focusing on Canada's national asylum system, I highlight how refugee claimants are constructed in irregularizing ways that allow for their regulation within and outside of the state, and the circumvention of their rights, specifically to healthcare. Here, I focus on Canada's Interim Federal Health Program (IFHP), which from June 2012 to April 2016, was drastically revised to correspond with other legislative changes that aimed to protect the integrity of Canada's refugee system and 'legitimate' refugees, by deterring 'bogus' refugee claimants from coming to/staying in Canada. The revision affected the life chances of many refugee claimants within everyday healthcare places, such as doctor's offices, hospitals, and walk-in clinics. Perhaps the most affected were refugee claimant women because the cuts targeted pre- and post-natal care coverage. But, women are also affected beyond the healthcare context; their asylum claims do not reflect the existing definition of 'refugee', which compounds their irregularity. As a result, I illustrate how they experience a gendered form of irregularity within and outside of healthcare.

This chapter highlights how refugee claimants in Canada are accorded an irregular status via humanitarian systems and programs which accord hierarchical positionings that determine who matters and who belongs. To demonstrate how irregularity is produced and experienced, I offer an empirical analysis of Canada's humanitarian healthcare program—the IFHP—within Toronto's everyday healthcare places. As a humanitarian program, the IFHP reflects how humanitarianism aims to save lives, reduce suffering, and enhance the welfare of vulnerable and neglected populations (Barnett 2013:380), while also undermining the very well-being of these populations (Ilcan 2013). This analysis of (the gendered experiences of) irregularity, as it is

shaped by humanitarianism, contributes to existing Canadian research on refugee populations in Canada (Diop 2014; Levine-Rasky et al. 2013; Levine-Rasky 2017; Macklin 2013) as well as the experiences of refugee women in seeking out and gaining access to humanitarian programs, such as healthcare (Brown-Bowers et al. 2015; Campbell et al. 2014; Dorman et al. 2017; Gagnon et al. 2013; Merry et al 2011; Tastsoglou et al. 2014).

Building on my analysis of irregularity, I demonstrate how this status, and the broader irregularizing assemblage, is contested through acts of liberating irregularity. Building on the acts of citizenship literature (Isin 2002, 2008), I approach acts of liberating irregularity as deeds or conducts that aim to free oneself or others from irregularity. They entail claims that assert presence and a right to be free from discrimination. While in previous chapters I detail the effectiveness of acts of liberating irregularity (chapters 3 and 4), in this chapter I offer a more critical analysis of acts as unintentionally working within irregularizing assemblages and therefore as maintaining irregularity.

In light of the above, the key question guiding this chapter is: how is Canada's asylum system irregularizing, and are there gendered effects? Also, how are the humanitarian actors who perform acts of liberating irregularity implicated in the continued irregularization of refugee claimants? Drawing on critical humanitarianism scholarship (Barnett 2013; Fassin 2010; Malkki 1996; Tickin 2011a), this chapter highlights how humanitarianism can be conceived of as an irregularizing assemblage and how asylum systems and programs produce irregularity. I organize the chapter into four sections. The first section provides a conceptual framework that establishes a connection between humanitarianism and irregularization. The second section discusses Canada's humanitarian system through an analysis of IRPA, the Protecting Canada's Immigration System Act (PCISA), and the IFHP. The third section offers an empirical analysis



of the gendered experiences of irregularization among Toronto's refugee claimant women, which is then followed by a discussion of how resistance efforts that sought to liberate irregularity maintained irregularization by working within a system that these acts aimed to challenge. Based on this analysis, I approach the politics of irregularization as an 'affirmative' one (Fraser 2008). I conclude by offering potentially transformative pathways to equity and justice for refugee populations in Canada.

### **The Irregularizing Assemblage of Humanitarianism**

Humanitarianism is understood as a response to injustice and suffering in times of crisis or emergency through the provision of various forms of relief, such as food aid, infrastructure development, medical assistance, training, education, and refugee resettlement. These actions are "taken in the name of a shared humanity" (Fassin 2010:239) that aim to save lives and respond to sudden and morally compelling crises (ibid.; Calhoun 2008:94-95). Humanitarian responses are informed by principles of neutrality, humanity, and universality (Barnett and Weiss 2008:3-4), and expressed in the language of duty, obligation, and responsibility (Barnett and Snyder 2008:143). However, this affiliation with welfare tends to justify dysfunctional, ineffective, and counterproductive practices, actions, and frameworks that may reproduce inequality and injustice and reduce the rights of refugees (Belloni 2007:454; Chimni 2000). For example, Ilcan et al. (2017) highlight how the humanitarian practice of self-reliance in Uganda's Nakivale refugee settlement aims to give refugees more control over their own lives but simultaneously offers a decontextualized managerial solution that violates the rights of refugees and forces them to participate in an environment where they face isolation, poverty, xenophobia, and inadequate access to social support. These practices of humanitarianism are justified through the

construction of the refugee as a dehistoricized and depoliticized “pure victim” who is stripped of authority and voice (Malkki 1996:378). The refugee victim is therefore constructed as reliant on the knowledge and intervention of experts who create solutions for suffering. As Baban et al (2017:83) note, the construction of refugees as victims prioritizes and normalizes the provision of temporary protection and assistance, and institutionalizes uncertainty and vulnerability, at the expense of rights and broader acknowledgments of structural issues.

In addition to the legitimization of the role of experts to speak for refugees, the refugee victim positions human beings as having different degrees of power and worth, which for Fassin (2010:239) highlights how “humanitarianism is founded on an inequality of lives and hierarchies of humanity”. Specifically, the victim status creates distinctions and subjects of difference not only among refugee populations (i.e. who is and is not a victim), but also between “those who have the power to protect, and those who need protection—those who suffer, and those who recognise and address suffering” (Ticktin 2011a:261). Here, we have two main actors—the protector and the sufferer—which reflects the inherently unequal power relations that define humanitarianism. The humanitarian relationship constructs and positions subjects in unequal ways. As Fassin (2010:239) alerts us, in the field of humanitarianism, it is not possible to recognize the sufferer as an equal; that position is always devalued against the protector who recognizes the claim of suffering by the victim.

While the recognition of suffering does not accord equality, it does yield access to protection, rights, and entitlements. Those who are determined to be a non-sufferer, or at least an uncertain or to-be-determined sufferer (as in the case of refugee claimants) are accorded a position or status that reflects their problematic out-of-placeness within the humanitarian system. It is through this status that states manage refugee claimants and their ability to access various

humanitarian resources and services. Ticktin (2006:44) offers insight on this governing function of humanitarianism in her analysis of France's humanitarian 'illness clause' which regulates mobility by choosing exceptional subjects over others to gain access to citizenship. Similarly, Walters (2010) draws attention to zones of humanitarian government that regulate racialized bodies and decipher whose life is to be fostered or abandoned, while Ilcan and Rygiel (2015) alert us to 'resiliency humanitarianism' which aims to responsabilize camp refugees and transform them into entrepreneurial subjects. These scholars render visible how refugee populations are subjectified through the power relations that define humanitarianism. I aim to contribute to this research by demonstrating how humanitarianism subjectifies refugee claimants as irregular.

In the Canadian context, refugee claimants represent one of many categorizations of persons who are seeking access to humanitarian protection and assistance offered through Canada's asylum system. In contrast to the Convention refugee whose suffering or fear of persecution has been recognized, refugee claimants have yet to prove their 'refugeeness', being "the institutional, international expectation of a certain kind of *helplessness* as a refugee characteristic" (Malkki 1996:388) produced by social, political, and legal constructions of the international refugee regime (Malkki 1995:506). It is this element of yet to prove that constructs the irregularity of refugee claimants within Canada's asylum system. In other words, they represent an abnormality in the context of refugeeness, and this is mostly due to how this population gains access to the system.

According to Ticktin (2011a:121), "humanitarianism often requires the suffering person to be represented in the *passivity* of their suffering", which effectively makes the act of seeking asylum problematic. To make a refugee claim requires moving on one's own volition rather than

waiting to be resettled. This positions refugee claimants as practicing an ‘*unsavoury*’ and ‘*dangerous*’ form of agency (Nyers 2003:1070), one in which occurs outside of regulated refugee pathways. As a result, refugee claimants are more susceptible to constructions of ‘bogusness’, ‘rule breakers’, or ‘queue jumpers’, and to increased problematizations of their presence within space, regardless of their right to be present<sup>33</sup>. This is largely due to the label of ‘claimant’. Drawing on Zetter (1999:2,8, cited in Chimni 2000:254), the label of refugee claimant establishes “certain assumptions and expectations about humanitarian treatment and responses”, and arguably assumptions about the characteristics of this population. Other scholars have made similar arguments. While Gorman (2017) and Sharma (2012) alert us to how labels, such as refugee and temporary foreign worker, respectively, delineate and manage movements at and within territorial boundaries, Isin (2002:34) argues that ‘other’ categorizations include attached negative meanings, images, and characteristics. In this light, the label of claimant not only works to determine how refugee claimants are treated but also how they are imagined (i.e. ‘queue jumpers’ or ‘bogus’). These imaginations justify certain forms of humanitarian treatment, such as how or if refugee claimants gain access to healthcare.

It is in this regard that I approach humanitarianism as an irregularizing assemblage, which includes international and national systems and programs, and various actors, knowledges, and imaginations that problematize the presence of persons/groups and render them irregular, regardless of legal status (see Hepworth 2014). Through the concept of assemblage, this chapter highlights how humanitarianism entails inconsistency and contradiction as a result of the various

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<sup>33</sup> According to Article 14.1 of the Universal Declaration of Human Rights, “everyone has the right to seek and to enjoy in other countries asylum from persecution” (OHCHR).

elements that constitute it (O'Connor and Ilcan 2001; see chapter 2). One important element is the humanitarian agent.

In everyday places, humanitarian agents—or those who work with refugees—negotiate and shape the realities of ‘humanitarian action’ (i.e. service delivery) according to various humanitarian principles that are used to advance or legitimize individual interests and beliefs (Hilhorst and Jansen 2010:1117-1118). This complements Landolt and Goldring’s (2015:856-7) work on how gradations of access to services are produced by individual interpretations of policies, regulations, and other elements, and “moral frameworks of deservingness”.

Deservingness is an important element in the irregularizing assemblage of humanitarianism. It positions “some groups but not others [...] [as] worthy of attention, investment, and care” (Yarris and Castañeda 2015:66). Because deservingness is subjective and relational in nature (Willen 2012:814), it is constantly shifting and under negotiation. In this chapter, I pay particular attention to how everyday healthcare actors’ ideas of deservingness are implicated in constructions of irregularity. This is made especially evident in section four of the chapter.

Building upon this conceptual framework, below I offer an analysis of Canada’s humanitarian context. Here, I discuss how legislative and program changes—IRPA, PCISA, and IFHP—were made to protect Canada from ‘bogus’ refugee claimants. What resulted was an increased targeting and questioning of the presence of refugee claimants, specifically within everyday healthcare places.

### **(Protecting) Canada’s Humanitarian System: IRPA, the PCISA, and the IFHP**

Canada’s history of offering humanitarian protection dates back to 1776 when 3,000 Black Loyalists fled the American Revolution in search of safety in the country. Throughout the

nineteenth century, the country offered safe haven to the Poles fleeing Russian oppression, the Italians fleeing state reforms, and Ukrainians fleeing Austro-Hungarian rule. In the twentieth century, Canada offered protection to Palestinian Arabs, Middle Eastern and North African Jews, Chinese, Chilean and other Latin American nationalities, Bengali Muslims, Tibetans, Ugandan Asians, Iranians, Vietnamese, and Cambodians. Today, the majority of Canada's refugees are from Syria, Iraq, and the surrounding region (Government of Canada 2017c). As a signatory to the 1951 UNHCR Refugee Convention, and its 1967 Protocol, Canada is obligated to protect and maintain the rights of refugee populations. Although Canada was presented with the Nansen Medal in 1986 for its humanitarian tradition of protecting refugees<sup>34</sup>, its stance has changed since the early twenty-first century.

In 2002, the Immigration and Refugee Protection Act (IRPA) came into effect as the primary federal legislation that defines the principles and regulations of refugee protection in Canada. IRPA curtailed the rights of refugee populations through: increased powers of detention; expanded inadmissibility categories; restricted rights to appeals; strengthened removal orders; and strengthened interdiction provisions (Jimenez and Crépeau 2013). Since its ascension, IRPA has been amended to further limit the rights of refugee populations. One way this was achieved was through the Protecting Canada's Immigration System Act (PCISA).

Introduced in 2012, the PCISA takes direct aim at the In-Canada Asylum Program, which according to Hari (2014:39) is particularly vulnerable to attack because it is an unregulated program whose applicants are perceived as "threat[s] to sovereignty, security, and national identity". Discussed as entailing measures that would strengthen Canada's "long and proud

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<sup>34</sup> It is important to acknowledge Canada's long history of racism and exclusion towards migrants (i.e. the Chinese 'head tax') and refugees (i.e. restricted entry of Jewish refugees).

humanitarian tradition” (Dykstra 2012), the PCISA: expedites the processing of refugee protection claims, specifically from Designated Countries of Origin (DCO)<sup>35</sup>; authorizes the Minister of Immigration to designate certain types of arrival as irregular<sup>36</sup>; expands the scope of human smuggling; and requires biometric information for temporary residency permits (Government of Canada 2012c). These measures target those who do not reflect the Convention ‘refugee’, specifically refugee claimants. According to a migration lawyer/advocate:

Canada would like to be selecting its refugees from its countries and deciding who will be coming and is thereby getting out the message that anybody who arrives in a different way, who’s not sitting in a refugee camp hoping that they are going to be one of the chosen few, is somehow doing it wrong, is jumping a queue, is illegal, is bogus, etcetera (Interview with Lawyer, Toronto, 7 October 2015).

Reflecting Zetter’s (1999) argument on the importance of labels, the construct of the refugee claimant as ‘bogus’ or ‘queue jumper’ justifies state responses to the movements of this population. As Casas-Cortes et al. (2014b:71) argue, “while the refugee protection regime is a humanitarian regime, it is only able to provide support to people if they obey and behave as demanded by the protection regime”. As ‘queue jumper’, refugee claimants are imagined as disobeying and misbehaving, and as therefore less likely to receive support and more likely to be targeted. Consider the following statement made by Conservative MP Scott Armstrong regarding ‘bogus’ claimants:

[they] were not in need of Canada’s protection [...] but they came anyway. They came to soak up our generous benefits and to try to jump the queue because they did not want to wait in line and follow the rules like everyone else. While here, these bogus claimants have access to our generous taxpayer-funded health care system and our welfare benefits (Armstrong 2012).

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<sup>35</sup> Also known as ‘safe’ countries, the Canadian government defines a DCO as respecting human rights and offering state protection, and therefore less likely to produce refugees. Forty-two countries have been designated as such. Those claiming asylum from one of these countries are processed significantly faster than non-DCO claimants (Government of Canada 2017b).

<sup>36</sup> Irregular arrivals are groups of persons whose identity cannot be deciphered in a “timely manner”, or whose arrival is related to criminal activity (Government of Canada 2012c).

Here, the bogusness of refugee claimants is connected with ideas and images of greed, theft, fraud, and exploitation; an image that is reminiscent of Anderson's (2017) discussion of the 'politics of pests'. The invasiveness of these 'bogus' others then warranted the types of regulation that defined the PCISA. According to the Conservative Party's Immigration Minister Chris Alexander:

We all win as taxpayers, as government-service providers, and as humanitarians when those who jump the queue, those who abuse our generosity, [...] and those who take advantage of our social programs, are forced to play by the rules, are held accountable. Bogus asylum seekers are not entitled to the same benefits as taxpaying Canadians or genuine refugees (Government of Canada 2014a).

The label of the bogus refugee is an attempt to further distinguish between refugee populations (Diop 2014:76) and justify extensive forms of regulation and control (Zetter 1999:2,8, cited in Chimni 2000:254). One example of regulation was in healthcare.

Since 1957, refugees in Canada have received healthcare coverage through the IFHP, a federally administered humanitarian program that was created as an emergency response to meet the needs of resettled refugees, refugee claimants, and other protected persons who were not eligible for provincial or territorial health insurance, or private health insurance (Canadian Doctors for Refugee Care, et al. v. Canada 2014:13). The IFHP pays for basic healthcare, preventative/supplemental coverage, and prescription coverage, as well as prenatal and obstetrical care. This coverage is equivalent to that provided to citizens and permanent residents on social assistance.

The IFHP originates "to a 1946 Order in Council that authorized medical coverage for some 4,000 ex-members of the Polish Armed Forces whom the federal government had selected for assistance with immigration" (Dhand and Diab 2015:356). This coverage was extended again in 1949 through another order to include migrants who lack financial resources, and again in



1952 to extend medical care, dental care, and hospitalization coverage to ‘indigent’ migrants and those waiting for work placements (ibid.). On 20 June 1957, Order-in-Council P.C. 157-11/848 passed which further amended the program to extend to a person who at any time is “subject to Immigration jurisdiction or for whom Immigration authorities feel responsible”<sup>37</sup> (Canadian Doctors for Refugee Care, et al. v. Canada 2014:14); this Order continued to define the program until 30 June 2012. The program was originally offered as a Health Canada program (formerly Department of National Health and Welfare) until 1995 when Citizenship and Immigration Canada (CIC) (now called Immigration, Refugee, and Citizenship Canada (IRCC)) took over control (CHA 2012:3). It was during this same year that refugee claimants residing in Ontario lost their coverage through the Ontario Health Insurance Plan (OHIP); Ontario altered the eligibility rules to deny OHIP coverage to temporary residents, meaning refugee claimants had to rely solely on the much less comprehensive IFH program (Canadian Doctors for Refugee Care, et al. v. Canada 2014:15; Sansom 1997:202-203). By 2012, the program covered 128,586 persons at an estimated cost of \$83 million to \$91 million (Canadian Doctors for Refugee Care, et al. v. Canada 2014:17; Dhand and Diab 2015:358).

In light of the increasing expenses of the program, and the increasing securitization of refugee claimants, CIC opted to review the program in September 2010 and reform it based upon five principles: to “modernize, clarify and reaffirm the original intent of the IFHP as a temporary [...] program”; to ensure ‘fairness’ to Canadians; to “protect public health and public safety in Canada”; to “defend the integrity of Canada’s refugee determination system and deter its abuse”; and to “contain the financial cost of the IFHP”<sup>38</sup> (Canadian Doctors for Refugee Care, et al. v.

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<sup>37</sup> These persons were not defined or identified.

<sup>38</sup> No economic analysis was released to substantiate these claims (Marwah 2014:11).

Canada 2014:18). This review culminated in the 25 April 2012 announcement that major changes would be made to the IFHP through Order-in-Council P.C. 2012-433, entitled the *Order Respecting the Interim Federal Health Program, 2012*. Alongside a 28 June 2012 Order in Council P.C. 2012-945, these orders repealed and replaced the 1957 Order in Council and instated a new IFH program on 30 June 2012. The rationale for the modifications can be gauged from a statement by Immigration Minister Chris Alexander:

Canada is second to none in its generosity and fairness, and this is reflected in our refugee system, but we have no tolerance for those who take advantage of this generosity and consume welfare benefits and precious health-care resources. Simply arriving on our shores and claiming hardship isn't good enough. This isn't a self-selection bonanza or a social program buffet (Government of Canada 2014a).

Through this revision, the humanitarian program was employed to regulate refugee claimants who were 'greedily' consuming Canada's social programs by denying/restricting access to healthcare coverage. Interestingly, during this time the Canadian government was providing medical services to (deserving/genuine) refugees overseas (see Payton 2012).

The new IFHP ranked refugees according to legal status, country of origin, and mode of entry, illustrating a type of division within refugee populations. Specifically, the program offered three different categories of healthcare coverage: expanded healthcare coverage; (basic) healthcare coverage; and public health and public safety (PHPS) coverage. Refugee claimants from a non-DCO received healthcare coverage, which included medical services, and access to diagnostic tests and hospital services, if they are 'urgent' or 'essential' in nature. Routine primary healthcare services, preventative healthcare, and medications/immunizations were not

covered, unless it was to prevent or treat a PHPS threat/risk<sup>39</sup>. For pregnant women, they received coverage for: consultation fees for their initial assessment and follow-ups; required tests; cost of delivery at a per diem rate; and post-partum follow-ups for 28 days after delivery. However, medication was not covered unless it was for a PHPS risk (CIC 2012:5-6). Refugee claimants from a DCO received PHPS coverage, which provided no services or medications unless to prevent or treat a PHPS threat or concern (Canadian Doctors for Refugee Care, et al. v. Canada 2014:23-24); this included pregnant women and children (CIC 2012:5-6).

The coverage provided through the revised IFHP could change depending on where one was positioned within the claims process, meaning that refugee claimants could be eligible for different types of healthcare coverage at different times. For example, a non-DCO refugee claimant received healthcare coverage, but if his claim was rejected he received PHPS coverage, whereby a refugee claimant from a DCO received PHPS coverage, but if her claim was accepted she received healthcare coverage. This confusion meant that doctors were forced to navigate a “complex matrix of impenetrable and incomprehensible degrees of coverage”, leading many to “just throw up their hands and give up” (Interview with Doctor, Toronto, 10 November 2015). In practice, this meant that people with healthcare coverage could be denied healthcare services or face restrictions to services, even if they continued to have coverage (see chapters 3 and 4).

The cuts generated a great deal of activism throughout Canada, and included government office occupations, interruptions of government officials, national days of action, and various campaigns (such as the Noncooperation Campaign, Fill the Gap Campaign, and 59 Cent Campaign) (see chapter 3). Healthcare professionals also created and distributed information

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<sup>39</sup> A PHPS *threat* includes tuberculosis, HIV, malaria, measles, and chicken pox. A condition posing a *risk* includes mental health conditions that may cause harm to the individual or others (Canadian Doctors for Refugee Care, et al. v. Canada 2014:25).

charts, published in academic journals, and participated in conferences and presentations to help provide clarity about the program, since the government provided very little assistance in this regard (Interview with Doctors, Toronto, 19 October, 20 October, 10 November, 2015). By far one of the most visible challenges came in the form of a Federal Court Charter challenge.

The *Canadian Doctors for Refugee Care*, the *Canadian Association of Refugee Lawyers*, *Justice for Children and Youth*, and two refugee claimants, Daniel Garcia Rodriguez and Hanif Ayubi, requested a judicial review of the federal government's decision to reduce coverage, arguing it was inconsistent with Canada's international obligations to refugees and in violation of Section 7 (the right to life and security of the person), Section 12 (cruel and unusual treatment), and Section 15 (discrimination) of the *Canadian Charter of Rights and Freedoms* (*Canadian Doctors for Refugee Care, et al. v. Canada*, 2014; CARL 2013). On 4 July 2014, the Court ruled the cuts were in violation of sections 12 and 15 of the Charter and ordered the government to introduce a revised program within a four-month timeline. The government appealed the ruling and requested to suspend the decision until the appeal was heard, which the Federal Court of Appeal denied (CARL 2014b). On 4 November 2014, the government introduced the 'temporary' IFHP since the government continued to appeal the court decision.

The 'temporary' program restored full coverage to pregnant women and children and gave refugee claimants coverage for medical, diagnostics, hospital services, and medications to treat PHPS threats, regardless of country of origin (Government of Canada 2014b). However, the complexity of the program intensified through the introduction of six types of healthcare coverage, with refugee claimants receiving 'type three' coverage. As one refugee doctor explains:

now there's different coverage if you're a child, versus if you're a pregnant woman versus if you're an active refugee claimant versus if you're from a

moratorium country versus if you're rejected before your date of deportation, if you're [...] port of entry claim, inland claim, and that's just refugee claimants (Interview with Doctor, Toronto, 20 October 2015).

The fact that refugee claimants were provided with increased but not full coverage demonstrated the importance of notions of deservingness and presence within the state. As can be gained from the above quote, the new program increased confusion among healthcare providers which led to even more denied services. The 'temporary' program worked to further shape how actors encounter refugee claimants as irregular in everyday healthcare places.

The above overview sets the foundation in which to come to terms with the irregularization of refugee claimants during the time of the IFHP cuts. Below, I provide an empirical analysis of how refugee claimants were irregularized within Toronto's everyday healthcare places from June 2012 to April 2016. This analysis differs from previous chapters in that specific attention is paid to women who actively navigate Canada's humanitarian asylum system. Through this focus, I demonstrate how irregularity is gendered, which contributes to discussions of the inequality, vulnerability, and marginalization that define the lives of women in Canada's asylum system (see for example Bhuyan et al. 2014; Bhuyan et al. 2016a, 2016b; Dauvergne and Millbank 2010; Hyndman 2010; See 2016). Considering that Canada has seen a steady increase in the number of women making refugee claims (Government of Canada 2013a)—who are largely considered to be some of the most vulnerable people in the world (Carman and Elash 2018)—it is important to focus on the specific experiences of this group.

### **A Gendered Approach to Irregularization**

Gender-related asylum claims made by women do not reflect the definition of 'refugee' set forth by existing international and national asylum systems (See 2016:26). In Canada, the most

common reason women seek refuge is to escape gender persecution, which includes forced marriage, female genital cutting, and domestic abuse, the latter of which accounted for more than half of the claims made by women between January 2013 to September 2017 (Carman and Elash 2018). However, according to a migration lawyer, these experiences of women “don’t neatly fit into the refugee rubric”. For example, Dauvergne and Millbank (2010) highlight how forced marriage is not considered to be a persecutory harm among refugee decision makers in Canada. An Executive Director of a women’s organization in Toronto elaborates on women’s experiences while seeking refugee protection:

the refugee system is not the most advantageous for the most part for women who experience violence because despite modifications and adaptations, the international definitions of what makes a refugee are really based on a male definition of experience of power, violence, state coercion, and statistically at the moment the greatest number of women affected by violence are affected by domestic violence globally and it drives their migration [...] what we traditionally think of as the refugee and what the legal system traditionally thinks of as the refugee [...] most women don’t meet that definition so the women who come here, every aspect of their situation is irregular to that system (Interview with Executive Director, Toronto, 26 November 2015)

This mirrors the view of Salcido and Menjívar (2012:342) who explain that many women are unable to obtain refugee protection because the fundamental need to prove persecution is “more in line with what are perceived to be men’s experiences than with what are perceived to be women’s experiences”. The irregularity of women results in denied refugee protection and increased vulnerability through restricted rights, entitlements, and protections, ‘despite modifications and adaptations’ that have been made.

The ‘modifications and adaptations’ mentioned in the above quote pertain to the integration of gender guidelines to Canada’s national asylum system in 1993, entitled the *Guidelines on Women Refugee Claimants Fearing Gender-Related Persecution*. The Guidelines affirmed that the definition of Convention refugee should be interpreted to provide protection for

women who demonstrate a well-founded fear of gender-related persecution and it offers principles to assist decision makers in accounting for gender-specific experiences of persecution (IRB 2016b). However, See (2016:32-34, 218) takes issue with the gender guidelines, particularly: its blindness to the intersectional nature of women's oppression; decision-makers' narrow interpretation of gender; the lack of a consistent approach to and understanding of the Guidelines as an evaluative tool; and the lack of consensus amongst decision makers on what constitutes gender-related persecution. These guidelines are further questioned in relation to the PCISA, specifically, the DCO category and its tighter timelines and restrictions on access to appeals (ibid:38-40). For example, while claiming protection from domestic violence is difficult to prove (IRB 2016b), those women from a DCO face restricted timelines to gain such proof and restricted appeals processes (Bhuyan et al. 2016b). The irregularity of one's gender-related claims results in fewer options to seek out safety and protection, increased exposure to interpersonal and structural violence, and the denial of fundamental rights, security, and access to services (Bhuyan et al. 2016a: 413,421).

Since many women do not reflect the definition of refugee, they have to navigate the system through alternative streams such as through the Humanitarian and Compassionate (H&C) claim. However, the decision can take years under this route. Furthermore, applicants must meet various requirements such as health standards and financial independence in order to be successful (CLEO website), but many applicants do not meet these requirements because they do not have the right to a work permit, meaning they rely on social assistance, and are denied healthcare coverage (Interview with Lawyer, Toronto, 11 November 2015). This overview of the positioning of refugee claimant women in Canada alerts us to their irregularity at a

national/international level. As I detail below, the presence of these women was also problematized within everyday places, such as healthcare places.

Within a period of a couple of years, the coverage provided to pregnant claimants shifted from denied coverage for pre- and post-natal care for DCO claimants, to increased coverage for pre- and post-natal care services but restricted access to medication, regardless of country of origin. This shift created confusion among healthcare professionals, which was compounded by the fact that coverage could still change based upon where one was at in the asylum process. For many obstetricians, the uncertainty of IFHP coverage led many to problematize the presence of women resulting in denied services. For example, a case exists of a 38-week pregnant woman who was denied care by her obstetrician unless she paid \$3000 on her next visit (Interview with Doctor, Toronto, 19 October 2015). A Program Manager of a newcomer organization in Toronto provides a similar story,

We've had doctors say well, this person's a refugee claimant, they're going to have their claim heard while she's pregnant, I can't fire her as a patient once she's my patient, so if she ceases to be eligible for healthcare, I'm on the hook so I won't take her to begin with (Interview with Program Manager, Toronto, 8 October 2015).

One doctor states that another important element of denied access to healthcare services was the indeterminacy that defined the 2014 'temporary' IFH program itself. Many obstetricians, who are longer-term healthcare professionals, came to target and construct pregnant women with the new 'temporary' IFHP as no longer eligible for services. As a doctor elaborates,

one of the interesting things this government did is they called it the *temporary* IFHP program. For many obstetricians, for example, if they pick you up now as a patient, they want to ensure that you'll still be covered thirty weeks later when you're delivering, and I think [...] that terminology when you say it's temporary, is a problem [...]. So many obstetricians we hear just aren't touching the program whatsoever. So more and more we are seeing people who should be insured but are still being turned away from care (Interview with doctor, Toronto, 19 October 2015).



This temporariness transformed the presence of IFHP recipients into one of instability, and therefore irregularity, within the standardized healthcare setting (see chapter 3). As a result, many doctors, as humanitarian actors, assumed they had to choose between having to care for oneself, (i.e. reimbursement or fees for services), or for the refugee (who may or may not have coverage) (see Vanthuyne et al. 2013:79). This choice reflects the unequal power relations that define the humanitarian relationship, and considering that pregnancy is “a common presentation” among refugee claimants (Interview with Doctor, Toronto, 20 October 2015), these relations must be carefully and critically (re)examined. However, the irregularity that undergirds humanitarianism, and that is experienced by pregnant women, leads not only to denied access to services but also discrimination.

The values attributed to the lives of refugee claimant women (and their babies) are based on an evaluation informed by status (see Turner 1989:5) and can lead to discrimination (Isin 2002:34). In the healthcare setting, discrimination can take the form of insensitivity, unfriendly behaviour, “racial slurs, stereotyping, and receipt of inferior care” (Pollock et al. 2012:63). One participant spoke to the discrimination that pregnant women face in the healthcare setting, such as prejudicial assumptions, racism, and social barriers, which led her to conclude that “newcomer women are more discriminated against, whether it’s intentional or not” (Interview with Midwife, Toronto, 22 January 2016). For pregnant refugee claimant women (and other un(der)insured precarious status women) in Toronto, many are recognized as ‘medical tourists’ who deliver ‘anchor babies’ (Villegas 2010, cited in Vanthuyne et al. 2013:81), complementing not only broader discourses of refugee claimants as greedy and threatening to the healthcare system, but also Tyler’s (2013:217) discussion of women’s bodies as ‘corporeal border zones’ controlled by the state (and arguably healthcare professionals in this case) to manage “the undesirable

reproduction of non-citizens”. According to Vanthuyne et al. (2013:79), negative perceptions of pregnant un(der)insured precarious status women are founded on “a process of defining who is considered a member of one’s moral community, and as such, ‘deserving’ of one’s care”. By focusing on the irregularization of pregnant women, this section sheds light on how everyday humanitarian spaces (i.e. the healthcare setting) and the humanitarian agents working within them (i.e. healthcare professionals) that the lives of this group of refugees is negotiated and shaped based upon various contradictory, inconsistent, and complex principles (Hilhorst and Jansen 2010:1117-8, 1120). The irregularity that emerges in these examples reflect a bioinequality (Willen 2011:304), in that irregularity in the healthcare setting can also be thought of as a reflection of whose lives and bodies matter. However, not all healthcare providers problematized refugee claimants. Some worked to liberate refugee claimants from irregularity (see chapters 3 and 4). Although these acts of liberating irregularity were well-intentioned, I discuss below how they in fact unintentionally maintained irregularization.

### **Saving Refugee Claimants: Doctors as Humanitarian Actors in the Office and on the Streets**

According to Fassin (2010:240), there are three different types of life at stake: “lives to be saved, lives to be exposed, and lives to be told”. Doctors and nurses in Toronto act as humanitarian agents who seek to save, expose, and tell the lives of refugee claimants and relay this information to governing authorities and the public in order to liberate refugee claimants from the status of irregularity. But as discussed above, their position is imbued with power; they designate situations as (non)emergencies and determine who receives (and does not receive) attention or concern. In these decisions, healthcare professionals have the ability to improve the welfare of individuals, or to diminish it. For those who seek to improve the welfare of refugee claimants,

they are involved in aspects of saving lives as well as exposing and explaining experiences of refugee claimants in doctor's offices and on the streets. I argue, however that despite these well-intentioned acts, the result was not one of challenging the irregularizing assemblage of humanitarianism, but rather sustaining it, reflecting Fassin's (2010:255) argument that the politics of humanitarianism (saving, exposing, telling) "cannot restore equality"; "inequalities of lives and hierarchies of humanity surreptitiously reappear—in spite of the humanitarian agents and often without their knowing it—between the persons who intervene and the persons they assist". As illustrated below, in their assessments of vulnerability and deservingness to save refugee claimants, doctors perpetuated a system that irregularized refugees—the very thing they were fighting against.

Prior to this, I want to provide a brief overview of how I conceive of acts of liberating irregularity. Building upon the work of Isin and his concept of acts of citizenship (2002, 2008; Isin and Neilson 2008), I approach acts of liberating irregularity as deeds that aim to free oneself or others from irregularity through claims that assert a right to be free from discrimination and assertions of presence. In the previous chapters (chapters 3 and 4), I detailed the importance of the performativity and solidarity that constitute acts of liberating. In this chapter, I approach acts of liberating irregularity through a more critical lens. While research has been conducted on the importance of acts within humanitarian contexts (Holzer 2013; Ilcan 2013; Lecadet 2016), I consider how acts effectively maintain irregularization and irregularity. I do this through an analysis of acts in the doctor's office and on the streets of Toronto.

### In the Office

Although significant restrictions to healthcare coverage were introduced through the IFHP, one

exception was maintained. Under Section 7, the Minister retained the discretion to provide coverage “in exceptional and compelling circumstances”. For example, one of the refugee claimants involved in the Charter challenge, Mr. Ayubi, was granted discretionary coverage for his diabetes-related medical services, but not for his medication since Ministerial discretion does not cover the costs of medications or immunizations unless to treat a PHPS concern or threat (Canadian Doctors for Refugee Care, et al. v. Canada 2014:26); as a failed refugee claimant under moratorium of deportation, Mr. Ayubi no longer received IFH coverage but he was unable to afford the cost of medications, leading him to rely on free samples of insulin provided through a community health centre (10-11; Interview with Executive Director, Toronto, 11 November 2015). Here, the state’s attempt to determine exceptional cases demonstrates how humanitarianism can simultaneously reduce the well-being of refugee populations.

In order to receive Section 7 coverage, doctors must witness vulnerability and plead a person’s case to the federal government. For example, Dr. Banerji of the pediatric clinic at St. Michael’s Hospital in downtown Toronto wrote a letter to the Immigration and Refugee Board (IRB) detailing the compelling and exceptional circumstances of a young mother who fled sexual abuse in Swaziland and was in need of access to healthcare coverage to test for HIV and receive treatment for syphilis (Global News 2012). Doctors also sought compassion in the case of Joseph Bernard, a failed refugee claimant from Pakistan who had no coverage for his terminal liver cancer treatments and medications but could not be deported because he was too sick (Yourex-West 2015a, 2015b). Both cases were awarded exceptional medical coverage. Section 7 is based upon the differentiation of some refugees as more deserving than others, and is reliant on the testimony of experts who provide an informative ‘rundown’ of diseases and other physical ailments; Malkki (1996:390) approaches this as exemplifying a form of “clinical

humanitarianism” that “erase[s] knowledge” and constructs a “raw humanity” of “pure helplessness”. The receive much needed healthcare, refugee claimants had to perform their ‘refugeeness’ to be deemed deserving. As Ticktin (2006:43) notes, such “face-to-face encounter[s] allows for performances on both sides, and if one does not perform in the desired manner, one may be penalized and excluded”. For those refugee claimants who did not perform in the correct manner, they were re-irregularized through the denial of assistance. It is in this light that we can see the powerful gatekeeper role of doctors (Ticktin 2006:42-44) and the complexity that defines the doctor’s office, where the humanitarian decision to ‘tell’ the life of a refugee claimant so as to ‘save’ them perpetuates cleavage(s). As I discuss below, these cases were also shared in the streets to garner support from the public for the reinstatement of the IFHP.

### On the streets

The encounters that doctors have with refugee claimants in the office make them first-hand witnesses to the forms of violence that refugee populations experience. In their attempts to rectify the injustices created through the IFHP, doctors visibly challenged the actions of the government through interruptions of government officials, occupations of government spaces, demonstrations, and campaigns. Some examples include the *National Day of Action*, and the *Non-Cooperation Campaign* (see chapter 3 for more examples). The underlying goal was to educate the general public on the implications of the IFHP cuts in order to gain the support for the program’s reinstatement. According to one doctor, advocates engaged in these public actions because the numerous letters written by national health associations to the federal government went unanswered, and calls to meet with members of the government were ignored or refused;

with “nowhere else to have an engagement with them”, the doctors went “to the public terrain” (Interview with Doctor, Toronto, 10 November 2015). In this terrain, doctors utilized ‘moral sentiments’ (Fassin 2012:1) to allow the public to see the suffering of refugee claimants and to shame the government on its treatment of this population (CDRC 2014; Las Perlas TV 2014).

Moral sentiments aim to make the experiences of refugee claimants visible by humanizing this population, or rather, by transforming them into “subjects who matter”, something that Tyler and Marciniak (2013:152) call ‘affective technologies of the close up’. For example, in speeches made at the *National Day of Action* in June 2014, activists shared stories of refugee claimants who were denied access to essential healthcare services or coverage, “caus[ing] them to become ill and possibly die here” (CDRC 2014). Although attempts to humanize are well-intentioned, they tend to occur at the expense of history, context, politics, and individuality (Beatson 2016; Malkki 1996). For Beatson (2016), they also tend to employ a victim frame. For example, during the IFHP protests, allies bestowed a ‘victim status’ to refugee claimants, entailing images of helplessness and passivity “to fit a certain narrative” (ibid:130). This is the narrative of ‘refugeeness’, which aims to transform the image of the refugee claimant from one of a bogus queue jumper to one who is legitimately present. In this light, allies not only engaged in a political resubjectification of refugee claimants as common subjects (see chapter 4; Castañeda 2013), but also a resubjectification that reflected the inequities of the humanitarian relationship. However, humanizing strategies can be effective in “provok[ing] publics to recognize ‘the human face’ of specific migrants” and “identify[ing] with migrants as ‘human beings’”—“as subjects who matter, ‘like us’” (Tyler and Marciniak 2013:152-153). Through humanizing strategies, allies may be able to establish an element of connectivity and mutuality between citizens and humanitarian subjects, and in the case of the IFHP, also gain public support

for the reinstatement of the IFHP. In their emphasis on refugee claimants, allies also unintentionally “exceptionalize[d] the deservingness” of this population over other refugee and migrant categories (ibid.). These include nonstatus populations, failed refugee claimants, and H&C applicants.

Protestors emphasized refugee claimants’ access to healthcare at the expense of other/ ‘other’ groups who are also denied access to healthcare coverage. For activists, the exceptionally irregularized presence and status of these populations could not be incorporated into IFHP advocacy efforts. According to one doctor involved in the *National Day of Action* in Toronto,

Our sole purpose was refugee claimants and I think that’s one of the reasons we were able to get the support of national health associations. If the goal was to insure all the million people who are uninsured, [they] wouldn’t have gone near it. It would’ve worked only for refugees. So that was a strategic decision, and we stuck to it rigidly and inflexibly and it worked (Interview with Doctor, Toronto, 15 November 2015).

In their attempts to call attention to the injustices faced by refugee claimants, allies remained complicit with a larger system of injustice that irregularizes the presence of other populations. For them, to be successful required the employment of rights norms that do not pose a challenge to state sovereignty, specifically, not posing a call for healthcare for all. Rather, the reinstatement of the IFHP was the safest and surest route. For Anderson et al. (2009:14), such prioritizations are not surprising; they argue that hierarchical differences created through national and international institutions are “often further ensconced by current social movements which advance the rights of only one or another particular state category of persons”. While it may be argued that refugee claimants were prioritized because they have a link with legitimacy—whereby other uninsured groups, such as undocumented persons and failed refugee claimants, do not—this population may have also been prioritized because of the very specific manner in which the IFHP cuts were framed. A doctor elaborates:

I think the way that that whole [IFHP] thing was framed was that we were all completely insured and then one government took away coverage from this small group of people and we should give them that coverage back. But there was actually often no acknowledgement of the broader pre-existing issue because if you were nonstatus, the refugee health cuts don't impact you at all. You didn't have health coverage before, you don't have health coverage after. So, I think there still isn't greater awareness of the fact that this is an ongoing issue and has always been an issue (Interview with Doctor, Toronto, 10 November 2015).

For this doctor, refugee claimants were prioritized at the expense of other groups because the context was fundamentally about the reinstatement of the IFHP, which did not provide the space to consider access to healthcare coverage for all. As a result, activists were blinded to the broader issue of healthcare coverage as it relates to all residents of Canada. The public activism during the time of the IFHP cuts would have provided the perfect platform for such discussions of healthcare coverage for all. Perhaps they would have reflected an extreme form of humanizing, whereby a connection of shared experiences would be made amongst all persons present within the state so as to establish one voice. Instead, by employing humanitarian framings that focused on suffering, saving, telling, and exposing, the underlying goal of improving the human condition was disregarded (Calhoun 2008:90).

By working within and accepting existing boundaries, the acts performed by allies reflect an 'affirmative' politics (Fraser:2008:22-24). Rather, what is needed is a 'transformative' politics that would focus on all people affected by Canada's healthcare system in order to generate a mutually supportive solidarity across boundaries, and to open up space in more equitable ways. Such a politics would also remind us of our shared contributions to Canada's healthcare system (Vanthuyne et al. 2013:84), reflecting the importance of the assertion of presence and claims of 'being here'.



## **A Way Forward?**

In their efforts to liberate the irregularity of refugee claimants, allies were unable to establish a systemic transformation. Reflecting on the issue of how to establish the rights of refugee claimants, a migration lawyer insightfully states:

there's so many intersecting issues. So, you can't address a policy change that affects healthcare but then you're still tying people [...] [to] not having access to a work permit, low social assistance rates, poor housing, you know? [...] I think it's a bigger question of how as a country we view migrants and their right to be here at all (Interview with Lawyer, Toronto, 11 November 2015)

For this lawyer, attention cannot be placed on one issue when so many issues affect the lives and well-being of refugee claimants in Canada, including the country's overall structural inclination to irregularize refugees. The question that arises then is how can we genuinely transgress irregularization, specifically as it relates to humanitarianism and the IFHP?

Perhaps we must call for a prioritization of rights, which would shift existing discussions surrounding access to healthcare from one of privilege to entitlement, and transform refugee claimants into political subjects who have a right to rights (Vanthuyne et al. 2013:84). This framework may also empower refugee populations to claim a right to have rights. This is evident in Kakuma refugee camp where women identify gender-based violence as an infringement of their rights, resulting in actions from governing bodies such as the UNHCR and norm changes (Hilhorst and Jansen 2010:1126). Rights-claiming does not need to be grand in scale. In her analysis of rights within the healthcare context, Willen (2011:325) states:

even when invoked in weakest mode, or when its potential for realization is next to nil, the notion of a right to health remains a powerful tool for all who reject commonsense assertions that certain people's diseases, sufferings, and lives are less important, less valuable, or less deserving of concern, than others.

While rights may be useful, Chatty (2017) argues that a rights-based approach may override a focus on moral responsibilities, meaning that we should instead be prioritizing duty-based

obligations. Other scholars however argue for a more transformative approach. For example, Malkki (1996:398) claims we should engage in a radical historicization of humanism that acknowledges suffering alongside “narrative authority, historical agency, and political memory”. This is complemented by Rankin (2010) who argues a need for an ‘ethics of accountability’ which encompasses a reflexive relationality that historicizes one’s own position in relation to the history of others, and commits to recovering perspectives and voices of the marginalized and oppressed; this is similar to Massey’s (2006) call for a ‘politics of responsibility’. In practice, these approaches appear as connections between corporate Canada’s exploitation and impoverishment of Guinea, with Canada’s responsibility to accept (not deport) Guineans (Engler 2017). Similar connections have been made in France by the Sans Papiers (McNevin 2006). This perspective is needed within our current context where the movements and claims of persons seeking entrance into Canada from the United States are highly problematized (Domise 2017). While all of these approaches yield a potential to transform our current context, what can be sure is that we need a focus on ‘the rights of persons’ (Sharma 2012:47) to address discrimination and injustice.

## **Conclusion**

This chapter focused on humanitarianism as an irregularizing assemblage within the Canadian context. Attention was placed on how Canada’s asylum system positions refugee claimants as irregular, with specific emphasis placed on women who largely do not ‘fit’ the established definition of ‘refugee’. As a result, this chapter shed critical light on the gendered experiences of irregularization. Furthermore, this chapter detailed how Canada’s humanitarian healthcare program—the Interim Federal Health Program—was modified in ways to regulate refugee

claimants. I detailed how this regulation occurred in Toronto's everyday healthcare places in ways that produced irregularity, specifically of women. I also illustrated how allies' attempts to liberate refugee claimants from irregularity in doctor's offices and on the streets unintentionally maintained irregularity. In this regard, this chapter highlights how the politics of irregularization is fundamentally affirmative. Overall, this chapter offered insight on how humanitarianism, which is founded on social justice and the alleviation of suffering, is implicated in the maintenance of injustice and suffering.

## **Chapter 6**

### **Conclusion**

How are we to conceive of the politics of irregularization? This fundamental question was the driving factor behind this dissertation and yet I conclude this dissertation without having a succinct response. Rather, irregularization is messy, contradictory, inconsistent, and productive of numerous pathways and experiences. Furthermore, the manner in which this is challenged is not immediately apparent, and sometimes occurs at the expense of actual ‘liberation’. However, this messiness is arguably an important element of research because it reminds scholars of the complexities of everyday life, particularly those that define the everyday lives of refugee populations. The purpose of this concluding chapter is to provide insight on the intentions of this dissertation. Specifically, it sheds light on how and why irregularization was chosen as a key concept, what it contributes to the literature, and why healthcare was chosen for this analysis. This chapter also highlights the importance of the conceptual framework that shapes this dissertation—being borders, (non)citizenship, and humanitarianism—and what this contributes to understandings of irregularization and critical migration scholarship more broadly. The chapter ends with some policy recommendations and a brief discussion of limitations and areas that would benefit from future research.

The manner in which I approach irregularization is an expansion of how it is currently conceived by critical migration scholars. I approach irregularization as an assemblage that works to problematize the presence of persons/groups within space, regardless of legal status (see Hepworth 2014), resulting in the attribution of an identity or a positioning that I understand as irregular status. Here, irregularization is understood along the lines of abnormality rather than illegality (Coutin 2010; DeGenova 2013; Squire 2011), representing a fitting conceptual

expansion considering Squire (2011:6) defines irregularization as produced through (ab)normalizations. Irregularization produces irregular statuses that reflect one's constructed abnormality within space, which occurs through a confluence of relations, encounters, and actors. This status effectively works to regulate refugee claimants' ability to access healthcare services and justify restrictions to healthcare coverage so as to deter claims making and/or the desire to stay in Canada. As a result, this concept alerts us to the nuanced ways in which refugee claimants, who are legal authorized temporary residents of Canada, are regulated in the Canadian context, and as a result, to how we can conceptually expand our understanding of regulation within the migration context.

The Canadian context is particularly fitting for this analysis because refugee claimants are increasingly subject to regulatory measures that do not so much affect legal status, but rather their positioning within the state (Diop 2014; Huot et al. 2015; Jimenez and Crepeau 2013). This was made evident in this dissertation through a focus on the IFHP, whereby the coming together of actors, documents, knowledges, encounters, data, etc., worked to position refugee claimants as irregular within everyday healthcare places and to therefore deny them access to essential healthcare services, regardless of their healthcare coverage. In this light, assemblage is a useful and insightful concept in which to analyze irregularization because it captures the messiness, inconsistencies, and contradictions of the everyday; it does not allude to a specific formation, integrity, involvement of elements, or persistence, and therefore, it allows scholars "to remain deliberately open" (Anderson and McFarlane 2011:124) to inconsistencies. As O'Connor and Ilcan (2001:1) note, "assemblages helps us to rethink the normal and the everyday and to re-vision the familiar in ways that express the present or the future as constantly under construction". Situated alongside discussions of regulation, the assemblage of irregularization

challenges notions of linearity, stability, and solidity that is assumed through ‘governance arrangements’ (Walters 2017).

What makes irregularization unique is the emphasis on status and presence. Building upon Turner’s (1989:2-5) definition of status as reflecting hierarchical positionings based upon forms of evaluation, I understand irregular status as a positioning that reflects how one’s presence is problematized within space. This attribution of identity arguably reflects a type of subjectification process, being a positioning of an individual that is crossed by power relations or the existence as subjects within constellations of power (Bigo 2011:45). A focus on status, rather than condition (Squire 2011) highlights how irregularity is not so much an outcome or state of affairs but is rather processual; it is contingently configured and (re)constituted in the everyday which not only shapes how we imagine and encounter others, but also life chances. Irregular status therefore alerts us to the many subjectifications that emerge through migration regulation (Mezzadra 2011), such as the victim subject (Fassin 2008) or the responsible subject (Ilcan and Rygiel 2015).

Presence is the second unique element of irregularization. Through a focus on presence—being one’s concrete location within space—ideas of regulation as affecting all migrant and refugee populations, regardless of status, is made possible. Furthermore, presence allows for an analysis of regulation within various spaces, not necessarily at the level of the state, which I demonstrate in my analysis of Toronto’s everyday healthcare places. I establish a connection between regulation and presence by focusing on how the latter is problematized. Problematizing presence hinders “association, recognition, status, and rights that come with being of the city” (Rygiel 2011:14), including rights to social and health services. In other words, problematizing presence veils over the relations and contributions of refugee claimants to the community, which

sometimes results from years of ‘being here’ (Keung 2017). It also leads to a questioning of the intentions and characteristics of those present. As a result, in interviews, participants noted the ‘hereness’ of refugee claimants to render arbitrary such problematizations and the enclosure of space that ensues. As one refugee claimant rightfully notes, “whether I am a refugee claimant or not, I am in your country. [...] I came here as a refugee. You took me as a refugee” (Interview with Refugee Claimant, Toronto, 18 October 2015). To assert ‘hereness’ or presence represents a challenge to irregularity, reflecting how governing actions can incite reactions as a result of its exercise over free subjects who refuse to submit (Foucault 1982:790). As Butler (1994:163) argues, “the constituted character of the subject is the very precondition of its agency”. In this regard, I view irregularization as productive of both regulation and resistance.

To analyze struggle, I engage with the concept of acts of liberating irregularity. Building on critical citizenship scholarship (Isin 2008; Isin and Neilson 2008), I define acts of liberating irregularity as conducts that aim to free oneself or others from irregularization/irregularity. This is achieved through claims that assert presence, and therefore a right to the rights affiliated with presence. The assertion of presence is powerful (DeGenova 2010; Nyers 2010; Rygiel 2012; Varsanyi 2008) because it represents a claim to legitimacy and membership in the community (Coutin 1999:60). In my analysis of acts of liberating irregularity, I highlighted how, through solidarity<sup>40</sup> and performativity, the relations between status, rights, and subjectivity were redefined in important ways. Here, assertions of presence from both refugee claimants and allies challenged the differentiation and discrimination that constitutes irregularizing migration policies and programs (Fassin 2012:136) within the healthcare context.

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<sup>40</sup> As Johnson (2014:200) reminds us, acts not only characterize the activism of marginalized populations, they are also “visible in moments of solidarity between non-citizen and citizen”.

As ‘acts’, acts of liberating irregularity reflect “moments, performances, enactments and events when a new identity [...] is brought into existence” and “when something, however small and seemingly marginal, is changed, possibly for the first time” (Walters 2008:192). For example, consider the emergence of an ad-hoc clinic in the basement of a refugee shelter in downtown Toronto after the IFHP cuts were introduced. According to the Executive Director of the agency,

what we did is, we had a very nice volunteer doctor, he started a small clinic [...] he was the only person coming two Saturday’s a month. He started opening the space, we started opening access to health for people who doesn’t have that access [...]. When we started, the only thing that we had was this room [...] and was only the table and the doctor was coming with his portable check-up, and now if you go downstairs three years later on, we have set-up a clinic (Interview with Executive Director, Toronto, 20 October 2015)

What makes this an act is the opening up of space to make a difference in the lives of refugee claimants and other un(der)insured populations. This ‘common’ space (Anderson et al. 2012; Casas-Cortés et al. 2014a), which does not discriminate against patients but prioritizes the healthcare of all persons, ruptures existing unjust and unequal practices and logics. As Castañeda (2013:238) notes in her analysis of undocumented migrant healthcare in Germany, the provision of medical care has the ability to disrupt unjust and unequal scalings of rights, status and membership, restructure “the terms of debate [...] by emphasizing the right to medical aid”, and invent new forms of connection. By establishing a connection between acts of liberating irregularity and commoning, I approach the “new identity [...] brought into existence” (Walters 2008:192) here as a common subject who refuses the suffering and discrimination of self and/or those who are present by rejecting the enclosure of space and prioritizing cooperation, reciprocity, recognition, and respect (see Federici 2010: 289, cited in Casas-Cortés et al. 2014a:457). Within the context of migration scholarship, the idea of a common subject who



emerges through acts of liberating irregularity works to challenge the differentiation that defines how scholars analyze resistance; rather than a focus on refugee claimants who constitute themselves as de facto citizens through acts of citizenship (for example see Müller 2016; Ní Mhurchú 2016; Nyers 2010), this dissertation highlights the importance of solidarity and how refugee claimants and allies work together in ways that enact an undifferentiated political subjectivity. However, I do not approach acts of liberating irregularity in a strictly romantic sense, but rather a realistic one that is attentive to the precarious location of refugee claimants within securitized contexts, and to the problems of solidarity. As a result, I do not approach acts of liberating as always necessarily transformative, but affirmative (see chapter 5).

In this dissertation, I situated my analysis of the politics of irregularization within the healthcare. This meant analyzing how the cuts were made to the IFHP, how they were interpreted within everyday healthcare places, how they impacted the lives of refugee claimants, and finally, how they were challenged. I focused on the refugee healthcare context not only because of the timely relevance of the IFHP, but also because it represents a manifestation of the regulation that was occurring in Canada at that time. Changes made to the Immigration and Refugee Protection Act (IRPA), especially through the Balanced Refugee Reform Act (BRRA) and the Protecting Canada's Immigration System Act (PCISA), established a securitizing and criminalizing context within the country that sustained practices of division, marginalization, and exclusion. Although these legislations have been critically analyzed by scholars (Atak et al. 2017; Huot et al. 2015), little research has been conducted on the IFHP, at least through a critical sociological lens. Existing research focuses on its history (Dhand and Diab 2015), discourses (Beatson 2016; Harris and Zuberi 2014; Olsen et al 2014), implications on employment (Jackson 2012) health-related effects on children (Evans et al 2014) and women (Brown-Bowers et al.

2015; Campbell et al. 2014; Dorman et al. 2017; Gagnon et al. 2013; Merry et al 2011), and healthcare providers' perceptions (Tastsoglou et al. 2014; Vanthuynne et al. 2013). In this regard, the contribution of this dissertation to critical migration scholarship is the case, because it shows us the importance of moving beyond Canada's legal framework and instead to social and health programs and policies which have similar regulatory intentions and effects. This shift in focus has already been demonstrated by scholars such as Ticktin (2011a) in France, and Castañeda (2013) in Germany. While this dissertation focused on the IFHP from 2012-2016, future research should attend to its temporal affects (Caulford and Rahunathan 2017; Levitz 2016; Narayan et al. 2017:8), seeing that Nyers (2010:141) argues, "time is a key factor in the logic of border management and control". However, irregularization is not limited to healthcare. The transportability of this concept has been demonstrated by Nyers (2011) who applies it to citizens, but it can also be applied to more recent happenings, such as the Safe Third Country Agreement (STCA) which works to problematize the presence of refugee claimants coming from the United States.

My approach to irregularization as assemblage required a conceptual framework that would allow for a grounded or more concrete understanding of the process in a way that reflects critical migration scholarship but also the everyday lives of refugee populations. This dissertation promoted an understanding of irregularization as one founded upon the concepts of borders (DeGenova 2013; Rumford 2006, 2012), (non)citizenship (Isin 2002; Isin and Neilson 2008; Sharma 2001), and humanitarianism (Fassin 2010; Malkki 1996; Ticktin 2011), all of which allow scholars to be aware of how categories and identities are constructed in ways that circumvent rights and affect life chances. Engaging with these concepts through the lens of irregularization effectively worked to transform them into irregularizing assemblages. In other

words, I approach borders, (non)citizenship, and humanitarianism as irregularizing assemblages that irregularize persons/groups such as refugee claimants. I approach borders as selectivity and verification controls that give rise to categorizations that circumvent rights, citizenship as emerging in relation to otherness which justifies the privileging of rights for some over others, and humanitarianism as identifying, classifying, and regulating populations through hierarchies of legitimacy and deservingness. The three empirical chapters of this dissertation (chapters 3-5) speak to each one of these concepts.

The empirical chapters in this dissertation offer important insight on how we can conceive of the politics of irregularization. Regarding chapter 3, which focuses on borders, I demonstrate how the border emerges in everyday healthcare places through standardized practices and verification controls, and how everyday healthcare actors are involved in a type of borderwork that reasserts the discrimination and inequality that constitutes irregularity. In chapter 4, which focuses on (non)citizenship, attention is placed on how healthcare, which is perhaps the defining right of Canadian citizenship, takes centre stage in the construction of irregularity. This chapter illuminates how citizenship is articulated in relation to the other in ways that create irregularity and justify the circumvention of rights such as cuts to healthcare, and how discrimination can emerge through encounters between refugee claimants and healthcare professionals. Finally, the chapter dedicated to humanitarianism, chapter 5, demonstrates how refugee claimants are irregularized due to their very positioning within a system that is structurally inclined to irregularize this population, specifically women. Insight is provided on how the humanitarian relationship between doctors and refugee claimants is constituted in such a way that (re)irregularizes claimants and others navigating this system. All of the chapters alert us to the various ways in which we can imagine acts of liberating

irregularity as momentary, affirmative, but nevertheless making a difference in the everyday lives of refugee claimants. Combined, the three empirical chapters shed critical light on how irregularity is produced, experienced, and challenged, and how we can conceive of the politics of irregularization which came to define a very tumultuous time in Canada's recent history. Specifically, these chapters demonstrate how healthcare programs and sites are very much involved in the regulation of refugee claimants through, what I understand to be, irregularization.

Alongside these chapter contributions, exist limitations. First, it was difficult to gain access to refugee claimants, meaning their voices were limited in this study (see chapter 2). Relatedly, the voices of female refugee claimants is needed considering the very specific issues and experiences that women face (see chapter 5). Future research on the IFHP would benefit from more direct engagement with refugee populations, especially women. It would be interesting to include such voices within research in mid-range cities rather than larger cities such as Toronto whose numerous resources may provide greater access to healthcare services as compared to, for example, Windsor or Waterloo. Although the focus on healthcare is important, it is also limiting. To focus on healthcare restricts engagements with the irregularization of refugee claimants in other service areas such as legal aid (Keung 2012), social assistance (Keung 2014), childcare subsidies (Keung 2018), and housing, the latter of which was perhaps the most prominent issue that emerged in the interviews. For example, a refugee claimant states:

[Landlords] believe that you are not working, that you are going to stay in the house and mess the houses. I went to [an address] last week. The lady that was taking me around the building said oh, what is your status? We only accept landed people. They only accept people that are landed! I looked at the woman and I wanted to ask that the refugee people that are not landed, do you want them going to live under the bridge or what?! (Interview with Refugee Claimant, 11 March, 2016).

In this quote, the participant is speaking to overt experiences of discrimination in the housing sector; arguably a form of discrimination that is reflective of irregularization. Other refugee populations, such as privately-sponsored refugees, also experience similar issues in Toronto (Chowdhry 2016). In this light, it would be fascinating to analyze the irregularization of resettled refugees to demonstrate the mobility of the concept as well as the commonalities among refugee populations in Canada.

Although limitations exist, the dissertation makes important contributions to the field of migration more broadly. Specifically, the dissertation makes policy, empirical, and conceptual contributions. Regarding policy contributions, I offer numerous recommendations that aim to rectify the ‘unintended consequences’ of the IFHP. First, I recommend the development of a centralized information system to ensure service providers and refugee claimants have detailed, up-to-date program information. This suggestion is offered in light of Ilcan’s (2013:4) argument that while knowledge can work to classify and differentiate people and places in ways that may create injustices, the sharing and exchange of knowledge also yields a potential to transgress injustice. Second, I propose that there be more direct, thoughtful, and equitable engagement between government officials, refugee populations, and refugee allies, specifically with the development of refugee programs and policies. The IFHP cuts were made without consultation from important stakeholders in the field. Establishing an space of dialogue provides grounded insight on existing contexts and potentially unforeseen implications. Third, I strongly support all (billing) healthcare professionals in Canada be required to enrol with the IFHP and accept those persons with IFHP coverage as patients. Distinguishing between and discriminating against patients ensures that IFHP recipients continue to be denied access to essential healthcare services. Fourth, I strongly recommend that IFHP coverage be provided to all refugee claimants

immediately upon making an asylum claim, regardless of making a claim inland or at a port of entry. A refugee claimant is a refugee claimant regardless of how they made their claim. Fifth, I suggest that more funding be provided to Community Health Centres (CHC) and Midwives. CHCs and Midwives are some of the most important actors in the healthcare sector, specifically for marginalized and un(der)insured populations. Increased funding would allow for the development of these important ‘common’ spaces (Anderson et al. 2009, 2012). Focusing on the importance of CHCs and Midwives easily lends to an argument for salaried healthcare providers. Complementing the above solution, my sixth recommendation is to build and improve CHC capacity and coordination. CHCs are not equipped to treat complications, and CHC-hospital agreements do not always ensure patients receive proper and needed healthcare services. It is also sometimes difficult to become registered at a CHC due to long wait times (Villegas 2013: 227-228) or due to catchment area restrictions. Improved capacity and coordination may help to rectify these issues. Finally, I strongly urge provincial and territorial governments/ministries to provide healthcare coverage to all refugee populations (in Ontario, this was offered until 1994). Giving refugee claimants provincial/ territorial healthcare coverage would put an end to the irregularization of refugee claimants within everyday healthcare places. As one doctor notes:

part of the issue with IFH has always been that it’s [...] federally funded whereas all the rest of healthcare is provincially administered. So, there’s a case to be made [...] for IFH to actually be switched to each province’s provincial health insurance so that it’s in keeping with the existing systems and people don’t have to struggle to access what they need (Interview with Doctor, Toronto, 20 October 2015).

The move to provide provincial/territorial coverage would also present an important transformative act of liberating irregularity in the field of healthcare, and may potentially incite other actions or effects that can lead to other important transformations.

Empirically, this project offers original insight on the IFHP via semi-structured interviews and discourse and policy analysis of relevant documents. It also offers unique insight on the program through the voices of refugee claimants themselves, which is greatly needed in analyses of refugee healthcare (for an exception, see Campbell et al. 2014). Finally, the dissertation offers conceptual contributions. I think the expansion of irregularization to focus on presence may allow for a greater connectivity among marginalized populations, not simply precarious status noncitizens. Specifically, it may allow for the development of what Fraser (2008:22-24) terms an all-affected principle, or a grounding in which to develop solidarity and a common voice, at least in Canada's healthcare system. Darling (2017:191) makes a similar argument: "a focus on presence foregrounds the possibility of political solidarities centred on common experiences of the urban across otherwise distanced constituencies". For example, other populations in Canada face restricted or denied access to basic primary healthcare services as a result of their constructed irregularity, such as undocumented persons, newcomer permanent residents, temporary foreign workers, and homeless and indigenous populations (Khandor et al. 2011; Labby 2017; Narayan et al. 2017; Purdon and Palleja 2018). The experiences of these populations are shaped by provincial and national healthcare systems that regulate movement through exclusionary identity construction and verification practices (see chapters 3 and 4). In this dissertation I demonstrate how refugee claimants without access to Ontario's health insurance program (OHIP) are problematized. But as one doctor notes, more awareness is needed about the other precarious populations who cannot access the healthcare system. They state:

we are talking about a system that [...] doesn't even acknowledge the fact that there are people that don't have access to the system. [...] I think the problem in Canada is that people don't know what to do with someone who doesn't have OHIP because a lot of healthcare providers, but even the general public, just think everyone has OHIP because we talk so much about a universal healthcare system [...] I actually think a lot of people don't know this issue exists even, and the issue

is growing. [...] I think people heard about it a lot more with the refugee health cuts, but again, I think the way that that whole thing was framed was that we were all completely insured, and then one government took away coverage from this small group of people and we should give them that coverage back, but there was actually often no acknowledgement of the broader pre-existing issue [...] So I think there still [isn't] greater awareness of the fact that this is an ongoing issue and has always been an issue (Interview with Doctor, Toronto, 20 October 2015).

There are an estimated 500,000 people in Canada without health insurance, and half reside in Ontario (OHIPforAll.ca). Future research on irregularization would benefit from a focus on these other populations. A final conceptual contribution made by this dissertation is the concept of acts of liberating irregularity, which offers a nuanced understanding of resistance as heterogenous and potentially contradictory but nevertheless important for refugee claimant well-being. These conceptual and empirical contributions shed new light on the creative ways in which regulation and resistance in the Canadian context are enacted.

In conclusion, I leave this project asking what does the future hold for the healthcare rights of refugee claimants in Canada? With the number of asylum claims on the rise within the country, alongside anti-refugee sentiments, the IFHP may once again be vulnerable to critique (Rumley 2018). However, if this is the case, it will be met with resistance. As one doctor states:

I think it's hard not to [keep fighting] [...] I will continue along with many many other people that are involved in these issues, working not just on access to healthcare but the broader immigration issues, the broader issues of poverty and social determinants. Aside from that, I will not be alone, so that helps (Interview with Doctor, Toronto, 20 October 2015).

The indispensable acts that emerge from such resistance efforts are important not only for refugee claimants but also for the subtle yet persistent challenges they pose to assemblages of irregularization and the arbitrary foundations upon which enclosures, discrimination, injustice, and the circumvention of rights are based.



This dissertation demonstrates the importance of the concept of irregularization in discussions of migration. Through this concept, we can better understand how experiences of discrimination, inequality, and injustice work to shape the lives of migrant and refugee populations. In this regard, future research involving attention to these factors would benefit from an irregularization lens, which expands how we critically engage with issues of regulation and resistance, viewing it as shaped through the governing systems that define migration: borders, citizenship, and humanitarianism. By doing this, we are given the space to establish connections not only between such systems, but also among migrant and refugee populations, and potentially other marginalized and vulnerable populations. This appeal to the interdependence of social relations, rather than specific (dependent) migrant/refugee subjects fosters important connective links and the development of a ‘common’ voice. Future research is needed which takes into account the conceptual expansion of irregularization, including research that interrogates the significance of connectivity. By doing so, we open the space to imagine and substantiate the ‘common’ subject whose shared experiences break down barriers and establish bridges towards equity and justice.

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