

**Health in Distant Fields:
An Ethnographic Study of Latin American
Migrant Farmworkers' Access to Health Services
in Canada**

by

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Ethics Statement



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Abstract

Canada prides itself on its universal healthcare system. Nonetheless, migrant farm workers, who have temporary resident status, face difficulties accessing provincial healthcare while in Canada. Interviews and institutional ethnographic analysis were conducted in the Canadian provinces of Ontario and British Columbia. This paper examines the barriers that temporary farm workers from Mexico and Guatemala face when attempting to access healthcare services in Canada. Ontario and British Columbia, provinces with differing healthcare coverage, were found to have the same barriers but at different magnitudes. The reinforcement of bureaucratic barriers in British Columbia restricts temporary farm workers from accessing medical services more so than in Ontario. As the numbers of temporary farm workers rise in Canada, provincial healthcare providers can improve access to medical care by taking into account the difficulties temporary farm workers are currently facing.

Keywords: Migrant Farm Workers; Latin America; Access to health care; Provincial health care

In memory of Amanda Huircan-Martinez: the sky is wide.

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List of Acronyms

AWA	Agriculture Workers Alliance
NAFTA	North American Free Trade Agreement
SAWP	Seasonal Agricultural Worker Program
TFW	Temporary Foreign Worker
TFWP	Temporary Foreign Worker Program
TLSWP	Temporary Low Skill Worker Program
TMW	Temporary Migrant Worker
TMWP	Temporary Migrant Work Programs
UFCW	United Food and Commercial Workers

Glossary

Neoliberalism	A political and economic system that promotes free-market capitalism
St. John's Clinic	Pseudonym of the clinic where I conducted my study
Watermark	Term used to distinguish clusters of themes in the data studied.

Chapter 1.

Introduction

St. John's¹ Staff: *"Hello, I'm calling from the St. John's Clinic. Our patient went to your hospital, but he was turned away because he didn't have cash on him. He has private health insurance, so would it be possible for you to bill the insurance company directly so that he can be seen as soon as possible?"*

Hospital Receptionist: *"No, he has to pay upfront."*

St. John's Staff: *"I understand that this is generally required, however, he doesn't have the means to pay upfront. Please, if you call COWAN, his insurance company, it can be arranged for the insurance to send the payment directly to you."*

St. John's Staff: *"No. If I go to his country, I am not given special treatment and I am expected to pay. Why should it be any different here?"*

(Conversation recorded in field notes, 2014)

Effectively, the receptionist is the gatekeeper at hospitals. Canada's theoretical mandate for access to health care for all residents in practice becomes access for those who can pay— particularly for those with temporary resident status. The sentiment that sustains and validates the Canadian health care system is: "universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay" (Thornhill, Law, Clements, & Stipich, 2008, p. 2). According to the Canada Health Act, all residents of Canadian provinces and territories are entitled to healthcare coverage. There are no legal provisions that exclude or preclude temporary foreign workers (TFWs) from registering into provincial healthcare. In fact, the Canada Health Act

¹ St. John's Clinic is a pseudonym used throughout this thesis to preserve the anonymity of the actual clinic.

stipulates that the wait period for registration should not be longer than three months for residents in any Canadian province or territory ("Canada Health Act," 1985). In 1957, the federal government passed new legislation that introduced national hospital insurance in every province in Canada (Armstrong & Armstrong, 2008). As a result of the Hospital and Diagnostic Services Act of 1957 and the Medical Care Act of 1966, Medicare became more accessible to all Canadian residents. In 1984, the Canada Health Act passed, reducing regressive practices such as extra billing and user fees (Touhy Hughes, Flood, & Stabile, 2004). Prior to these changes, Canadians had to rely on churches and charitable organizations for their health concerns (Braën, 2002). Inspired by the system implemented in Saskatchewan by Woodrow Loy and entrenched by the work of Tommy Douglas (Premier of Saskatchewan from 1944-1961), the aim was to give all residents in Canada access to adequate and basic health care (Armstrong & Armstrong, 2008). As of 2008, approximately 70 percent of the Canadian health care system is financed through a taxpayer system, and the remaining 30 percent is paid through the private sector (Thornhill et al., 2008).

Since the implementation of the Canada Health Act in 1984, Canadian residents and citizens take pride in, and depend on, the health care system. There are population pockets within Canadian society, however, that experience a number of barriers when attempting to access health care services. Through the Seasonal Agricultural Work Program (SAWP) and the Temporary Foreign Work Program (TFWP), temporary migrant farm workers are granted temporary resident status whilst in Canada. As Dennis Raphael states: "the nature and extent of health inequalities— which are primarily a result of living conditions— provide good indicators of the role that the social determinants of health play in everyday life and well-being" (Raphael, 2010, p. 15). Despite being temporary residents, TFWs' health needs are not being met while they are in Canada.

This thesis explores how migrant farm workers from Mexico and Guatemala (who migrate to Canada under two different TFW programs) access provincial healthcare services in Ontario (ON) and British Columbia (BC) and which obstacles impede timely access to medical care. It posits that there is a lack of awareness from provincial health care providers of the realities migrant farm workers face, which negatively impacts migrant workers' access to health care. A literature review of the topic is followed by a description

of how the study was conducted. The results of the study are presented in the Discussion of Findings, followed by a series of public policy recommendations in the Conclusion.

1.1. Literature Review

The scholarly literature focusing on TFWs in Canada tends to illustrate three main themes: an analysis of the forces generating this migration (Otero & Pechlaner, 2009; Otero, 2011; Pechlaner & Otero, 2008; Preibisch & Encalada Grez, 2010), the conditions migrants face whilst working in Canada (Basok, 2004; Otero & Preibisch, 2010; UFCW, 2011), and an analysis of the structures and policies supporting the SAWP (UFCW, 2011; Basok, 2004). Additionally, the reports written by the United Food and Commercial Workers Union (UFCW) (UFCW, 2011) detail the working conditions and contextualize the experience of temporary migrant workers in Canada. These works will be discussed further below. Though there are a number of different programs under which temporary migrant workers enter Canada, this thesis will focus on program participants that work in the Canadian agricultural sector as the living and working conditions are unique: schedule requirements, the physical labour, and the contracts are different from those of Live-In Caregivers and of temporary workers in the food and mining industry. Research by Habiba Zamman on the Live-In Caregiver program has identified a different set of barriers affecting program participants from accessing healthcare while in Canada.

More specifically regarding the SAWP, three areas have been covered by scholars and civil society organizations (Preibisch & Encalada Grez, 2010; Sachs & Alston, 2010): the social network migrants rely upon (Basok, 2004), the experience of women workers in the Canadian agriculture sector (Preibisch & Encalada Grez, 2010; Basok, 2003; McLaughlin, 2008), and how migrant farm workers access medical care (McLaughlin, 2007, 2008, 2009, 2011, and 2012). Within this research, the trend is to compare women's experience to that of men's (Preibisch & Encalada Grez, 2010), and, to the best of my knowledge there are only three studies that discuss the experience of SAWP women alone (McLaughlin, 2008; Sachs & Alston, 2010; Preibisch & Encalada Grez, 2010). In other

literature focusing on varying aspects of the SAWP where women are mentioned, the focus is on their role as mothers or wives (Basok, 2003; Hanson, 2006).

Scholars discussing the reasons behind TFWs' migration tend to focus on the economic forces generating migration (Preibisch, 2004; Otero & Preibisch, 2010; Otero, 2011; Portes & DeWind, 2004): developed nations need to fill sectors in which their citizens have no interest in working, developing nations rely on foreign remittances (in addition to needing to alleviate population surpluses and unemployment), and large-scale migration occurs because people's livelihoods in their home country are diminishing (due to neoliberal policies and/or environmental changes). In the case of Mexican migrant workers, the North American Free Trade Agreement (NAFTA) has been signalled as a force affecting farming communities in Mexico that disrupts peasant-based rural economies (Otero, 2011; Otero, Pechlaner, Liberman, & Gürcan, 2015). This work also addresses how international agreements (such as NAFTA) can be contextualized when studying the wellbeing of migrant farm workers in rural parts of Canada.

The report "Farmworker Health and Safety: Challenges for BC" (Otero & Preibisch, 2010) discusses the labour conditions migrant farm workers face in the Canadian province of BC. This investigation sought to find out what kind of working conditions migrants face and how these could be ameliorated. In addition, it provided a comprehensive analysis of the SAWP policies. The precarious working conditions outlined in this report highlight the abusive circumstances that can exist in TFW programs. Studies such as this one are crucial because they provide an insightful analysis, whilst also pinpointing areas where improvement is needed. For example, there are different groups aiding SAWP workers to ameliorate these circumstances: local communities, non-governmental organizations, churches, unions, WorkSafeBC, local government, farmers, and farm hands. The Otero and Preibisch report calls for (among many other suggestions): bilingual safety training for TMWs, certified decent housing and transportation conditions by local government, and for the Canadian government to grant permanent residency status on arrival, which would allow workers to travel with their families (if they choose to), and change employers if needed (Otero & Pechlaner, 2015).

In her study “Post-national Citizenship, Social Exclusion and Migration Rights: Mexican Seasonal Workers in Canada”, Tanya Basok states that there is a severe lack of awareness of the types of services and procedures Mexican migrant workers need to access once in Canada (Basok, 2004). These include: claiming their pension upon reaching the age of 65, submitting claims for refunds for prescribed drugs bought whilst in Canada, and compensation from the Workplace Safety and Insurance Board if injured on the job. Basok posits that this situation is due to three factors: fear of being fired from work, a lack of education on migrants’ rights, and language barriers (Basok, 2004). Fear is an emotion permeating the lives of workers; fear of getting hurt whilst on the job, of not receiving proper medical attention, the expenses medical services could cost, fear of being jobless and unable to continue work in the SAWP, or even remaining as an eligible SAWP candidate in the future. Basok’s research methodology varies depending on the articles she writes on the SAWP and TFW permits (relying on quantitative and qualitative data at different times, as a result of the scope of her work). She does refer back to human rights discourses often, however. She consistently argues that neoliberal policies have led to an erosion of human rights as well as deteriorated local structures in developing nations (Basok, 2004). She uses interviews to support her arguments, in addition to using the work of other scholars to verify or add to her analysis. Basok’s scholarly work provides a comprehensive background of the intersection between human rights discourse and the realities of temporary migrant worker programs.

Women represent a particularly disadvantaged group in the agricultural labour force as there are fewer numbers of them working in the fields, which can lead to their being stigmatized by gender alone (Sachs & Alston, 2010). In scholarly discourse on female agricultural migrants, women that do participate in the agricultural sector tend to be studied under the role of wife, mother, or daughter of a male farmer portraying them as being an inherent and completely dependent component of a family unit. Preibisch and Encalada Grez in their study of women’s experience as migrant farm workers in Canada, argued that:

Temporary migrant worker programs further entrench existing structures of labour segregation in farm work. Further, they grant employees access to a highly vulnerable group of workers— people who embody the economic, social, and political marginalization within their home countries— who are then placed at a disadvantage within the Canadian labour market through

a range of legal disenfranchisements that hinge on their immigration status as noncitizens (Preibisch & Encalada Grez, 2010, p. 291).

Until 1998, only Mexican single mothers were allowed to partake in the SAWP (UFCW, 2011). This focus has distorted the perception of migrant women's role in agriculture in Canada— withholding the agency exercised by women whilst also entrenching the patriarchal structures of the agricultural sector. Women's labour can be perceived, therefore, as solely tied to the existence of an extreme need for them to support their families rather than a desire, or competence, to work in the agricultural sector. Kerry Preibisch, Evelyn Encalada Grez, Christina Hanson (2001), and Tanya Basok have studied the experience of women who are connected to the SAWP program by either direct participation, or through their spouses.

Scholarly literature on migrant women from Mexico to the United States of America or Canada focuses on the tensions women face in the domestic sector, inadvertently tying women to the homestead rather than studying their contribution in the agricultural field (Stephen, 2007). Therefore, the agricultural field is reinforced as being a male-dominated space where women's experiences are of minor importance. In large part, this neglect of women workers is due to the small number of women that partake in the SAWP which is placed between two to five percent of the total workforce (UFCW, 2011; Sachs & Alston, 2010; Preibisch and Encalada Grez, 2010). The differences in gender needs also become apparent when seeking and receiving medical attention as cultural traits framing gender norms affect the timing and type of medical care sought.

Medical doctor and anthropologist Seth Holmes' book *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States* studies the impact farming has on undocumented migrant workers in the United States from a physical, psychological, and social perspective (Holmes, 2013). Holmes weaves his medical and anthropological training to create an ethnography that encapsulates the migrant experience holistically and reduces the gap between two worlds: those that produce the food, and those that solely consume it. Basing his work on Pierre Bourdieu's concept of structural violence, which "indicat(es) the interrelations of social structures of inequalities and perceptions" (Holmes, 2013, p. 44), Holmes studies the physical effects of wider socio-political structures on migrant farm workers of Triqui ethnicity who journey from Mexico to work in

California and Washington. A study comparable to this one has yet to be undertaken in Canada. There is a strong need to research how the provincial health system is impacting simultaneously the physical bodies of migrant farm workers from medical and anthropological perspectives.

Seth Holmes' notes on the effects of "clinical gaze" as an important component of the fear that prevents workers from seeking medical attention are helpful. Based on the case of a migrant worker named Abelino, Holmes explains:

First, as might be expected in Foucault's paradigm of clinical gaze, physicians in migrant health (...) value their own observations and biotechnical testing of the patient's body over the words of the patient. (...) Second, physicians blame their patients for their suffering. Lacking the time to fully explore the problem and unable to see the transnational and local structures affecting Abelino's body, the rehabilitation medicine specialist indicated that Abelino's pain was the result of his behaviour; that is, he was "picking incorrectly (Holmes, 2013, p. 124).

Indeed, migrant workers are aware of the lack of understanding on the medical side, which could impact their care negatively. Though Holmes' work is based in the United States of America, the similarities in the obstacles and especially in the fear that prevents patients from seeking medical care are comparable to the cases interviewed in Canada.

There are a number of civil-society organizations that try to voice migrants' needs and support them in various ways. These include: church groups, advocacy groups (such as Justicia4MigrantWorkers), and unions. The UFCW has a sub-branch called the Agricultural Workers' Alliance (AWA). A report is compiled yearly outlining the context and trials its members face. The UFCW obtains their information through interviews with its members, as well as cases that the union supported. As such, these reports should be treated as primary rather than as secondary sources. The UFCW has the advantage of having direct access to workers, documenting their collective and individual cases by region and farms. Though some of the cases presented are exceptional and represent extreme circumstances, they are testaments to the level of hardship migrant workers do endure in Canada. Rather than generate questions, these reports seek to expose the negative traits TMWPs can have on the individual worker.

1.2. Research and Thesis Overview

The question that guided this research is: What barriers do migrant farm workers face when attempting to access health care services in the Canadian provinces of BC and in ON? Janet McLaughlin's work has focused on migrant health access in ON. An ethnographic comparative study on the realities of migrants' experience in accessing health care in BC and ON, however, has yet to be undertaken; particularly focusing on the effects of provincial health coverage and the type of TFW program workers come under. Studying the Canadian health system and the jurisdictional division of labour and/or overlap of responsibility between provincial, federal, and local governments sheds light on the scaffoldings migrant farm workers have to navigate in order to access and receive medical attention. Moreover, specific attention will be paid to six main barriers hindering this process: access to transportation, language, cultural differences, gender expectations, institutional knowledge of the health care structures, and continuity of care.

Chapter 2 will discuss the analytical framework and research methodology used in this study: institutional ethnography, interviews, and analysis of documents related to health that migrant farm workers receive. This will be followed by a presentation and discussion of the findings in Chapter 3: migrant farm workers in ON have an easier time accessing health care services than those working in BC. Such contrast is due to two differences: in 2014, SAWP farm workers in ON were covered under provincial health care from the moment they arrive, while in BC they could only apply three months after arrival (though seldom did). In 2016, the Mexican Consulate personnel assert that the provincial medical services plan is more expensive than the private insurance that is mandatory under the workers' SAWP contract. This creates a reliance on the insurance carrier mandated by their contract, which results in SAWP workers needing to wrestle with a bureaucratic force in order to see a physician. This study found that workers ended up self-selecting out from receiving medical care, as they were unable or unwilling to deal with these bureaucratic systems and that health care providers were not aware of the barriers migrant farm workers experienced when attempting to access medical care. In short, the health care system in BC is not providing the same level of care for migrant farm workers as ON— though both provinces have ample room for improvement. The concluding chapter recapitulates the main analytical issues discussed in this thesis,

proposes an agenda for future studies, and makes public policy recommendations based on the findings of this research project.

Chapter 2.

Methodology and Context

In the international scene, Canada is portrayed as a beacon for human rights; it is painted as a just society, which provides access to health care for all who reside in its midst. When I immigrated here in 2007, I was surprised to learn about the challenges migrant farm workers experience whilst living and working in the fields of BC. In order to understand the discrepancy in health care received, I chose to pursue an ethnographic study comparing the realities of migrant workers in two different provinces. I faced a series of challenges in conducting this study; the distance of workers from urban centres meant it was difficult to contact workers in BC, the politicization of how migrant farm workers are viewed (within civil society organizations) made conversations difficult to start, and the fear of being identified by their employers or authorities as troublesome made many workers uncomfortable answering questions (and I did not insist).

This project did not focus on the medical conditions of workers and patients interviewed; indeed, no records were kept of the types or specificities of injuries, ailments, or reasons why migrant farm workers were seeking, or had sought, medical attention. Though medical records were accessed as part of my role as Follow-Up Coordinator with St. John's Clinic, no medical records were used for this study. Rather, the focus was on the workers' experiences when seeking medical attention, what steps they needed to follow, what roadblocks they experienced, and how the health care system responded to their needs.

Based on Dorothy Smith's Institutional Ethnography methodology, data was gathered in three ways: through ethnographic research, interviews with migrant farm workers as well as with medical supporters in ON and BC, and through an analysis of the administrative records of the St. John's Clinic. Both the interviews and the records from 2014 were analyzed through a watermark system designed to identify cases when barriers presented themselves. This watermark methodology is explained in sections 2.3 to 2.6

Dorothy Smith describes institutional ethnography as follows:

Institutional ethnography is committed to exploration and discovery. It takes for granted that the social happens and is happening and that we can know it in much the same way as it is known among those who are right in there doing it. With this major difference: institutional ethnography is committed to discovering *beyond any one individual's experience* including the researcher's own and putting into words supplemented in some instances by diagrams or maps what she or he discovers about how people's activities are coordinated. (Smith, 2005, p. 1)

Institutional ethnography was chosen because it provides a platform to study the interactions and effects between bureaucratic (institutional) systems and the individual. It enables the researcher to map out data that would otherwise be lost, such as subtle signs of emotional response to concrete objects (for example, an insurance form). By acknowledging the interaction between an institution and the individual, the researcher can understand broader connections. By mapping out how migrant farm workers access health care services, we can observe how they navigate the institutional requirements (i.e. health insurances) and interact with them (accessing follow-up health care with medical facilities). Such mapping allowed me to address the relevant concerns in the scholarly literature.

Data was collected in three ways:

- 20 interviews with migrant farm workers at AWA centres
- 80 follow-up cases out of 250 at St. John's clinic
- 20 interviews with organizations and individuals that support migrant farm workers

Before the data analysis is presented in Chapter 3, a description of the different temporary visa programs will provide background information.

2.1. Seasonal Agricultural Worker Program and Temporary Work Permits

There are two types of temporary work programs to bring foreign labourers into Canada's agriculture: The Seasonal Agricultural Work Program and the Temporary Foreign Worker Program. The SAWP brings in migrant labour solely for the agricultural sector. Since 2011, the TFWP has been used to bring workers to the agricultural sector

also, though the conditions and terms of this arrangement differ from those of the SAWP program (Government of Canada: Employment and Social Development Canada, 2016). Farmers in BC and in ON are bringing in workers under both programs to supplement the Canadian labour force. In order to be eligible for either program, Canadian employers have to prove that there is a need to bring in temporary workers because not enough Canadians are able to do the work (or have applied for it under existing wage and other labour conditions).

Human Resources and Social Development Canada oversees both programs, however Citizenship and Immigration Canada approves the temporary work permits for both SAWP and TFWP. The TFWP was formerly known as Temporary Low Skill Work Program (TLSWP) (Stastna, 2012). Both the SAWP and the TFWP fall into the category of Temporary Migrant Work Programs (TMWPs). BC and ON are highly reliant on migrant workers to support their agricultural sector. Given that the agricultural sector pays minimum wage and no overtime, few Canadians see working in this sector as an appealing career path (Carman and O'Neil, 2013). As a result, employers bring in TFWs and often choose which program and country to bring workers from; for example, an employer can request workers from Guatemala under the TFWP and Mexican workers under the SAWP (or Jamaicans). This creates a tense working environment for migrant farm workers, making it harder for them to feel comfortable to seek medical attention when needed because they are afraid to stand out in public areas (Basok, 2004) and because they are afraid of competition from workers in other programs. Additionally, scholarly research conducted by Tanya Basok has demonstrated that there is a severe lack of awareness of services and rights that migrant workers hold (both on the part of employers, and employees) (Basok, 2004).

Temporary migrant worker programs provide developed nations with the advantage of having a reliable workforce that can be called upon or dismissed, depending on the need of the country's economic sectors without making major social or political commitments to these workers. Because of the flux of the labour market, migrant workers are aware of the precarious nature of their job contract. If they transgress work, cultural, or social norms, workers can face repatriation (Preibisch & Encalada Grez, 2010). Repatriation has long and short-term effects: it reduces the source of income for the family

of the migrant (thus affecting their immediate reality) and, secondly, it lessens the migrant's chances of participating in a program of a similar nature in the future.

2.1.1. The Seasonal Agricultural Workers Program

The SAWP started in 1966, and began accepting women in 1989 (UFCW, 2011). In 2016, twelve countries participated in the SAWP program: Mexico, Anguilla, Antigua and Barbuda, Barbados, Dominica, Grenada, Jamaica, Montserrat, St. Kitts–Nevis, St. Lucia, St. Vincent, and Trinidad and Tobago (Government of Canada: Employment and Social Development Canada, 2013). In 2014, the majority of SAWP migrant workers in BC came from Mexico (Government of Canada: Employment and Social Development Canada, 2013). In ON, Jamaicans and Mexicans are the two largest nationality groups to participate in the SAWP. McLaughlin and Hannebry's research has explored the barriers Jamaican SAWP workers experience in ON.

Migrant workers accepted into the SAWP have to meet the following criteria:

- Must have experience in farming
- Must be married and have a family to return to
- Must pass a medical examination, conducted by Mexican doctors in Mexico, asserting them fit for labour

(Hennebry & Preibisch, 2012)

Provided employers are satisfied with their labour, SAWP farm workers can return yearly for eight months at a time. It is not unusual for SAWP workers to return every season; indeed, there are cases of migrants participating for over 30 years in the program (Sook Lee, 2003). Though the medical check-ups are meant to be annual, participants in this study said this was not always the case if they had been enrolled in the program for a number of years.

2.1.2. Temporary Foreign Worker Program

The TFWP permit has fewer limitations than the SAWP. From ethnographic experience with migrant farm workers, I have observed that the majority of migrant farm

workers in BC and ON under the TFWP are from Guatemala, though there were not as many TFWP in ON as in BC. Migrant workers under this category can stay up to 24 months, after which they have to take a yearlong break before applying for the program again (Government of Canada: Employment and Social Development Canada, 2016).

According to Immigration, Refugees and Citizenship Canada, there were 19,946 seasonal Mexican farm workers in Canada in 2014, compared with 15,817 in 2010. In B.C. alone, the numbers increased to 4,521 from 2,986 in the same five-year period. Ramirez's 24-month temporary foreign worker contract provided for pay of \$10.50 an hour, a 40-hour work week, time-and-a-half pay beyond that, 60 minutes in breaks per day, two days off a week, and two weeks' vacation — but no sick days. (Pynn, 2016, p. 2).

Migrant workers from Guatemala have the same contract in BC and in ON— however, in regard to their health, they experience differences. In Ontario, TFWs are covered by provincial health care from the moment they arrive (based on data gathered in 2014). In BC, by contrast, they have private health insurance (usually arranged by the employer) for the first three months they are in the country, after which MSP enrolment should begin (based on data gathered in 2014). Few participants, however, had the amount of time off cited above. Table 2.1 showcases the similarities and differences between the SAWP and TFWP.

Table 2.1: Comparison Between Temporary Work Programs

Seasonal Agriculture Work Program:	Temporary Foreign Work Program:
Maximum stay of 8 months	Maximum stay of 24 months
Employer must provide housing	Workers have to arrange own housing arrangements
Employer is responsible for transportation to the worksite and grocery store once a week	Workers are responsible for own transportation at all times
Workers are represented legally by national consulate (broker of the contract between parties). Consulate responsible for monitoring living and working conditions	Worker brokers contract with employer. No one is responsible for living conditions.
Migrant workers are contractually obligated to purchase COWAN insurance package (both in BC and in ON).	Migrant workers are covered by the provincial health plan
Migrant workers pay into federal and provincial tax system	Migrant workers have to pay into the federal and provincial tax system
Migrant workers can only work in the Canadian agricultural sector	Migrant workers can work in any capacity defined as "low-skilled" and the employer has demonstrated that there is a Canadian shortage of workers
Employers must give workers allotted work hours; once completed, migrant worker must leave Canada when the contract has been fulfilled	Employers have no set obligation for allotted work hours; migrant worker can stay in Canada to find other work
Medical coverage provided through provincial health system (though workers cannot claim MSP in BC). Private insurance required in BC from first day of arrival	Employers are required to purchase health coverage for the first three months until workers are eligible for provincial health plan

(Table compiled from a variety of sources: (Basok, 2000; Foreign Agricultural Resource Management Services F.A.R.M.S., 2012; Hennebry & Preibisch, 2012; Otero & Preibisch, 2010; Stastna, 2012; UFCW, 2011))

As demonstrated in Table 2.1: Comparison Between Temporary Work Programs, SAWP workers' relationships between their national consulate and their employer are more structured than TFWP workers. Moreover, TFWPs' contracts specify fewer responsibilities from the employer towards the temporary migrant worker in terms of living arrangements and access to transportation. For the purpose of this study, only Mexican SAWP workers were interviewed in order to assess access to health care within similar TFWP cultural population group (Guatemalans). Additionally, Mexican SAWP workers

share the similar language realities as the other group studied: knowledge of Spanish and, in some cases, of indigenous languages.

2.2. Study Sites

Interviews were conducted in British Columbia and in Ontario, two in provinces. Sections 2.2.1 and 2.2.2 describe the locations where research was conducted.

2.2.1. St. John's Clinic (BC, Canada)

St. John's clinic is an alias for a walk-in clinic operating in BC that migrant farm workers access. The clinic has asked to remain anonymous in this study, which is why few details are provided. The clinic's work is not the focus of this project. Instead, being at the clinic was a way for me to see and understand how migrant farm workers access health care— a window of sorts into the bureaucratic healthcare world. I started by shadowing the St. John's Clinic team at their office. In order to fully immerse myself in this institutional-ethnographic project and in an effort to contribute to the organization, I took on the role of Follow-Up Coordinator during the summer of 2014. Particular attention was placed on the steps a patient had to take after the physician's visit in 80 cases where follow-up care was required in order to assess what hindered access to health care.

2.2.2. Agricultural Workers Alliance (BC and ON, Canada)

The Agricultural Workers Alliance (AWA) is part of the United Food and Commercial Workers of Canada union (UFCW) and the AWA has workers' support centres both in BC and in ON. In 2014 they closed down the support centre in Surrey, BC, due to budget cuts, but kept the centre in Abbotsford open. The AWA centre in Abbotsford is open from May until September, the months when there are the most migrant farm workers in the Fraser Valley, BC. In 2014, 2015, and 2016 the AWA centre had one staff member attending to the needs of the migrant workers, though the UFCW has other staff that support unionised farm workers across Canada. The AWA centres in Abbotsford (BC), Leamington (ON), and Simcoe (ON) were visited for this study. All of 20 interviews I

conducted with migrant farm workers in BC and in ON were held inside the AWA office with the union's consent.

The town of Leamington, ON, receives the largest number of temporary migrant farm workers in Canada each season: it is estimated that 5000 workers arrive for every season (CBC News 2013). Leamington has been receiving temporary migrant farm workers since the introduction in 1966 of the Seasonal Agricultural Work Program in Canada. This is because Leamington is the tomato capital of Canada; Highbury Canco has a plant there that buys the tomatoes produced in the greenhouses in the region (CBC News, 2014). Previously owned by Heinz, the plant closed in 2014. Farms in the area, however, still depend on a migrant labour force. There are also a number of canning factories, greenhouses, and frozen food companies that hire migrant farm workers – which enabled me to interview a sample of the migrant population working under the SAWP and under Temporary Migrant Work Permits. Interviews were conducted in Leamington with community health partners that provided medical care to migrant farm workers. Research was also conducted in the locations of organizations that provide assistance to migrant farm workers, such as union offices in Simcoe, ON. In total, I conducted seven in-person interviews with migrant farm workers in ON and five in BC. In addition, I interviewed seven people who provided support to migrant farm workers in ON, and eight in BC.

2.3. Watermarks

In order to compare the existence of barriers between both BC and ON (keeping in mind the different types of data acquired) a watermark score system was developed and applied to the qualitative data. A watermark is a transparent logo that appears on photographs: the main image is visible, and though the watermark does not tend to distract from the focus of the work, it is still present. Similarly, in this study there were markers that appeared in all the interviews I conducted as affecting health care access (or not). Sometimes the watermarks were more explicitly present, and sometimes the markers did not greatly affect the worker's experience in attempting to access medical care and yet watermarked (to different degrees) the decision-making process. In total, thirteen watermarks emerged from the interviews conducted in BC and ON. Excerpts of interviews are included below each watermark's definition.

The interviews were encoded into three response types:

- In cases where the participants responded in the affirmative (meaning that they had experienced the healthcare access barrier), a score of 2 was given. “Experienced” is used broadly in this context- for cases when the barrier prevented access to healthcare, or in cases when it was present to a higher degree
- In cases where the barrier was neither discussed nor presented as a barrier, a score of 1 was given.
- Lastly, in cases where the participant discussed a barrier but it had not affected their access to health care, a score of 0 was given.

The “score system” used in this study does not place significance on the numerical value; rather, it’s purpose is to be able to see which watermarks are more present than others in order to plot them. For example, when a participant disclosed that he was driven to a medical appointment by a third party (such as a community member, or the employer), a watermark for transportation was awarded the score of 2, as the participant’s ability to attend the appointment hinged on the person providing transportation. Had the participant not had the transportation provided by a third party, they would not have been able to get to the medical appointment without relying on someone else; though access existed, it was contingent on the willingness of the third party and on the third party’s schedule. Since the participant had to disclose to a third party that they were seeking medical attention, a watermark for Confidence/Privacy was awarded a score of 2 also– a third party had been informed because the participant had to disclose this need in order to access the medical service. Numbers close to 2 indicate migrants found this watermark to be a barrier, whereas a score closer to 0 indicates that the watermark barrier was not present or not discussed. A score of 1 was given when a barrier was neither discussed nor presented.

The symbol “J:” stands for a prompt question that I have asked the research participant. “[REDACTED]” stands for information regarding the medical ailment that the participant was describing– this information has been removed in order to maintain confidentiality, and because the focus of this project was on the experience of accessing health care, not on the types of injuries migrant workers experience while in Canada. All participant names have been coded to insure anonymity. Excerpts of the interview have been presented first in Spanish so that the participant’s voice is their own–the interpretation in English provided below each quotation is my own.

2.3.1. Transportation

This watermark refers to a reliance on a third party for transportation; the third party's schedule and availability would influence the process of arranging a medical appointment, or arriving at the medical appointment. In the context of St. John's Clinic, it could be for a time the patient asked for help with transportation, or coordination for transportation support occurred. In an ideal case, a participant would be able to have access to transportation without needing to inform anyone about this need- thus, independence would not be negatively impacted.

A migrant farmworker in BC explains how he was able to see a physician– he asked a church member for a ride:

Spanish:

Así fue como vine al médico. Ella me trajo. Ella me ayuda a venir al médico (M1A).

English:

That's how I came to see the doctor. She brought me. She helped me come see the doctor (M1A).

When asked how he made it to his medical appointment, this migrant farm worker from ON said:

Spanish:

El Patrón me llevó. (M1S)

English:

The boss took me. (M1S)

In the first case, the migrant farm worker depended on a church volunteer for a ride to see a physician, as he was not able to get to a clinic without transportation assistance (transportation score awarded: 0). In the second case, the worker's employer was the one providing the transport (transportation score awarded: 0). In both cases, the workers had

to find means of transportation by asking another party– thereby disclosing their need to see a physician. As a result, the worker’s privacy was lost.

2.3.2. Language

The “language” watermark was assigned in cases when a patient relies on a third party for language interpretation, or the third party has no formal medical interpretation training, which can create distrust and/or uncertainty of comprehension of the medical problem. This can potentially affect the patient’s agency in making an informed decision about treatment choices, as the patient’s understanding of condition(s) may not be accurate. In the context of St. John’s Clinic, the Language watermark can also appear in cases where the medical interpreter attended the appointment with the patient, or a community support volunteer interpreted the conversation.

An ON migrant farm worker shares his experience:

Spanish:

Y sí es un poco complicado, por cuestión de que...de que no hay quién nos interprete, en cuestión de...platicar con los doctores. En cambio, pues, cuando...esta persona de Pablo², pues si es él que– hay veces en que nos ha echado la mano. Para la interpretación. Pero sí, como cuestión de...ósea, [algo] personal, sí es algo difícil porque uno no puede [pausa] expresar su dolor, o expresar su– como...decir pues qué parte le duele, cómo siente, simplemente. A veces por eso no...no nos entendemos. Hay veces que es difícil para– ahora sí, como quién dice– para que a uno le den la medicina adecuada. (M1)

English:

Yes, sometimes it is complicated, because there isn’t...there is no one to interpret, in cases when...we talk to doctors. When, well, when...this person Pablo, he is the one that– there’s times when he gives us a hand. He interprets. But yes, when it comes to...well, personal [stuff], it is difficult because one can’t [pause] express our own pain, or express their– how...can I explain. Like, what part hurts, how one feels, simply put.

² Pablo is a pseudonym for a worker from the AWA in Leamington, ON.

Sometimes because of that we don't...understand each other. Sometimes it is difficult to— well, simply put—to get the right medication. (M1)

A migrant farm worker from BC says:

Spanish:

Porque yo pienso que sí, si es bueno...sería muy conveniente que sí tuviera algunos traductores, también. [J: Unos traductores?] No digo que en todas partes, porque, pues es por decir que a veces no se puede. ¿Verdad? [J: Sí]. Este...pero, sí, sería muy bueno eso de...de que hubiera unos traductores en las clínicas. Para...para estar MÁS, más más...más seguro, pues de lo que uno tiene, de lo que...a lo que va. Sí. A lo que venga. Pues sí, para poder entender más mejor eso. Sí. (M1AB)

English:

I think that yes, yes, it would be good...it would be convenient to have interpreters, also. [J: Interpreters?"]. I don't mean everywhere, because, well, sometimes that is not possible. Right? [J: Yes] But...but, yes, it would be very good to...to have more interpreters in clinics. Because...well because that we could be VERY very very...very sure, of what one has, and where ...one is heading. Yes. To [be prepared] for what is coming. So yes, so that we can better understand that, yes. (M1AB)

In the first case, the worker shares that it can be difficult to express oneself through an interpreter because one cannot be certain as to what the physician is hearing (language score awarded: 2). Similarly, the second worker thinks that it would be useful to have clinically-trained interpreters so that the patient can feel certain that the treatment chosen is the correct one and they can understand the implications (score awarded: 2).

2.3.3. Financial

The requirement to pay upfront before receiving medical attention may have impacted the decision to seek medical care and prevented participants from accessing it; if so, the “financial” watermark was given. In the context of St. John’s clinic, a patient might have chosen to cancel a booking because of fear of cost. If the clinic offered to cover costs on behalf of the patient and process reimbursement procedures with the insurance directly, a score was awarded. If the participant needed help dealing with the insurance for reimbursement, the watermark was present. The participant also cited finances as a

fear preventing access to treatment. Needing assistance with the processing of finances can have a negative impact on the patient- and in some cases, increases the likelihood that a patient will “self-select” out of care because they do not want to deal with the bureaucratic procedure. As a result, a person needing medical attention may delay care, or forgoe care completely.

In ON, a woman farm worker shares a conversation she had with a colleague:

Spanish:

OF2: Y con eso que dice la señora ahí que tiene 14 temporadas– dice ella que sí aquí hay que cuidarnos, dice, porque si aquí te enfermas– aquí los patrones no te pagan tus ocho horas de trabajo. Y luego si vas al doctor, tú tienes que pagar. Que no te pagan. (OF2).

English:

OF2: That lady who has been working here for 14 seasons says– we have to take care of ourselves, because she says that if we get sick here– the employers won’t pay you your eight hours of work. And then if you go to the doctor, you have to pay. They [the employers] don’t pay. (OF2).

In this case, the worker is fearful of being sick because she thinks she will lose her daily salary and, in addition, is afraid of having to pay for medical costs out of pocket (financial score awarded: 2). In this instance, both watermarks for fear and for finances are simultaneously present.

2.3.4. Culture

If participants were fearful of breaching social norms about work, then the “culture” watermark was present. This could lead them to avoid medical attention, or, as a Mexican criollo³ physician from ON who had worked in Mexico explains:

And again, because of my previous experience in Mexico...so, I had realized in Mexico fairly early on– if you tell the patient “take this twice a day”, twice a day to them doesn’t mean divide the day in two, therefore every 12 hours. Twice a day, in their mind, means I take it now, and I can

³ In this case, criollo is defined as a person of Spanish descent.

take it 6 hours later. Technically, I took it twice a day. Or 3 times a day, I'll, you know...so it's pretty much a random event. So, before they actually even leave my clinic, I explain to them: "I'm going to give you this medication, and I want you to take it twice a day. Meaning: take it this time, and take it this time. Or whatever time you want, but within 12 hours. And you consistently take it at approximately that time until it's finished, or whatever the case may be." So I've been able to get around that, but I haven't actually noticed it– but only because I am aware that it does happen. (Dr. Albert⁴ in ON).

Dr. Albert has made a conscious effort to share his experience with the team in his practice. His insights shed light on some of the challenges physicians encounter when treating patients from a different culture: there is an intrinsic assumption by the physician that the patient understands the expectations of the treatment in the same way as the physician does. The lack of familiarity with cultural norms can be the last straw that pushes to “self-select” out of care, thus impacting his overall health.

2.3.5. Fear

The “fear” watermark was assigned when participants were afraid of admitting that they were sick to either themselves or to the employer; also expressing a general uneasiness at the prospect of having to seek medical care. Participants were afraid to lose their job if they asked for time off for a medical appointment.

An interview participant from BC says:

Spanish:

Bueno, en mi caso, yo no estoy enfermo. Y solo que...que un poco de dolor de cabeza, es...algún dolor de estómago, o alguna torcedura...es...leve. Así, irme al medico? Nooo. (M1AB).

English:

Well, in my case, I am not sick. It's only that...well, sometimes I have some headache, or...some [REDACTED] pain, or maybe a

⁴ Dr. Albert is a pseudonym for a Mexican/Canadian physician who treats migrant farm workers in ON

[REDACTED]...but...it is light. So, going to the doctor just like that? Nooo. (M1AB).

A participant from ON shares his thoughts:

Spanish:

Pues aquí muchos de nosotros nos reservamos a no decir lo que sentimos, pues muchas veces, porque pues el patrón hay veces que no—no el patrón, si no que los mismos compañeros decimos: “se van a reír, o no se...se van a... que algo, pues.” Y sí, por eso se atiende uno, pero pues es de no callarse. ¿No? Es...de “siento algo, pues, voy al médico, pido permiso ir al médico.” Pero si es no callarse. Así. (M2).

English:

Well, here a lot of us, we prevent ourselves from saying what we feel, because many times— well because of the boss, there’s times that—well, not the boss, but even we ourselves say “they are going to laugh at us, or I don’t know...they are going to— well, something.” And yes, that’s why one doesn’t get cared for, because, well, it should be about not staying quiet. No? It should be... “I feel something, so I’m going to the doctor, I ask for allowance to go to the doctor”. It shouldn’t be about keeping it quiet, that way. (M2).

When asked if she presently needed medical attention, a woman migrant worker said:

Spanish:

OF1: No, señorita, no. Años pasados, sí, pero ahorita no. Ahorita no. Y digo gracias a Dios porque, digo que—pues ahí esa señora nos—nos dejaría morir si necesitábamos del medico.

English:

OF1: No, miss, no. In past years, yes, but not right now. Not right now. And thank God for that because —well, because that lady [referring to her employer]— she would let us die if we needed a doctor”

In the first two cases, the workers were aware that the employer’s knowledge of potential sickness could affect their contract (score awarded: 2). In the last case, the worker does not trust her employer would help her receive medical attention if she needed it (score given: 2).

2.3.6. Institutional Knowledge

The watermark for institutional knowledge was applied when there was a lack of familiarity with and/or misunderstanding of the bureaucratic steps needed in order to access medical care (example: what documents to bring to the medical appointment, or how to file an insurance claim).

Excerpt from an interview in ON:

Spanish:

M1: Lo que pasa es que automáticamente nosotros– cuando, por ejemplo, cuando uno viene a...a atención médico, uno presenta su carta. Su...carnet. De seguro. Y ya...automáticamente...no se cómo se, cómo se...se comunica el seguro con los médicos– no se. Simplemente nosotros enseñamos nuestra tarjeta.

J: ¿Ese es seguro privado o seguro de Canadá– de la provincia?

M1: Mmm...pues no sabría decirle. Simplemente es una tarjeta verde, no sé. (M1).

English:

M1: What happens is that we automatically– when, for example, one arrives at...at the doctor, you present your card. Your...carnet. Of insurance. And then...automatically...I'm not sure how, how...it communicates with the doctor's insurance–I don't know. We simply show our card.

J: Is it a private insurance or a Canadian insurance–from the province?

M1: Mmm...well, I wouldn't know what to tell you. It's simply a green card, I don't know (M1).

When prompted to explain how the insurance worked, the migrant worker did not know which type of coverage he had (score given: 0).

2.3.7. Confidentiality/Privacy

If the participant had to inform and rely on a third party in order to access health care, then the Confidentiality/Privacy watermark was present.

M2 is a Spanish-speaking migrant farm worker who was a patient in Ontario and asked his employer (referred to as the “encargado de la farma”) for time off. He shares his experience when he needed medical attention and a bilingual (Spanish-English) co-worker (referred to as “muchacho”) interpreted the conversation between the English-speaking physician and the Spanish-speaking patient M2:

Spanish:

M2: Fui aquí con un doctor. Hablé con el encargado de la farma [sic], y este...y le dije que sentía un dolorcito aquí en el [REDACTED]. “Y mira sabes qué,” le digo, “traigo pendiente ya una cita a un doctor.” Y este...y me dijo que— y le dije que si me la pudiera dar. Y me dijo que sí. Este...ese mismo día, en la tarde, fui. Mmm. Me llevó, y este...me consultó el doctor y todo. Me checó donde estaba el dolor, porque yo pensé que era la [REDACTED]— y no era mi [REDACTED], el médico me dijo que era [REDACTED]— ahí pues que el [REDACTED] se inflame y todo eso. Y este...y ya estaba preocupado, pero bendito dios que todo salió bien.

J: Ya. ¿Y quién— cómo hizo para hablar con el médico?

M2: Mmm... un muchacho de ahí de la farma [sic]— habla español. Y él estaba [pause] [J: ¿traduciendo?] traduciendo. Mmhm.

English:

M2: I saw a doctor here. I spoke with the employer, and...and I told him that I had a pain here [REDACTED]. “And you know what”, I told him, “ I have an appointment with the doctor pending”. And he told me that—and I told him if he could take me? And he said yes. And...and that same day, in the afternoon, I went. Mmm. I was taken, and...the doctor assessed me and everything. He checked where the pain was, because I thought it was [REDACTED]— because it can get inflamed and all of that. And, well...and I was worried, but thank God everything was fine.

J: Okay. And who— how did you communicate with the physician?

M2: Mmm...a guy from the farm was there—he speaks Spanish. And he was [pause]

J: Translating?

M2: Translating. Mmhm.

In this case, the migrant worker disclosed his physical ailment to his employer, and relied on a co-worker to interpret the medical consultation with the physician (score given: 0).

2.3.8. Guilt/Imposition

If participants delayed their decision to access medical care because they felt guilty about needing to rely on a third party, or in cases when they scheduled their visit to coincide with the schedule of the driver, a “guilty/imposition” watermark was assigned.

A worker residing in BC explains that when he does not inform his employer he needs to access healthcare, he calls a volunteer from his local parish instead:

Spanish:

Pero hay veces que no le decimos [al patrón], porque a veces tenemos tiempo ahí– y con las señoritas de las iglesias que nos apoyan. Y ahí va (...). Tal vez– también para ellos ir hasta su casa y todo y tomar eso en cuenta también. Entonces no, pues. Sí queremos porque nos ofrecen mucho su ayuda: “si quiere a un médico, o algo” y pues a veces le decimos: “nooo, pues sí, sí queremos ir al médico” Ósea, sí puede ser. Para que le resulta a ellas también bien ¿Verdad? Ey.

English:

M1AB: Sometimes we don’t tell him [the employer] because we don’t have time– so it is the ladies from the church who help us. So it is (...). Sometimes we think about the fact that they have to go all the way back to their house and other places– so we keep that in mind. In those cases, we don’t go. We do appreciate it because they are always offering to help us: “if you want to go to the doctor or anything”– so sometimes we say: “well, actually, we do need to go”. So, sometimes it is possible [to go to the doctor]. But it has to work out for them [the church ladies] also. Right? Yeah. (M1AB).

Participant M1AB has been part of the SAWP program for a number of years in BC. He knew that local churches have volunteers from the parish that support migrant farm workers– but he was also careful with how often he asked for their support– so as not to overtax them (score assigned: 2).

2.3.9. Gender

If the participant’s gender affected their access to health care (or their concern was gender-specific), then the “gender” watermark was present. For example, both women I

spoke with in ON expressed concern about the lack of access to gynaecologists while they were in Canada. In Mexico, women do not see their general practitioner for obstetric and gynaecological concerns and it is common for the husband to be present at the medical appointment. Both women were wary about going to see a physician in Canada without their husband present, and they did not know how to access a gynaecologist. Whilst interviewing them, they asked for the recorder to be turned off for this part of the conversation– but they agreed to let me take notes of their concerns. The lack of information on medical services for women can have a negative impact on the patient's health as conditions may not be treated in a timely manner.

2.3.10. Contact

In cases where the participant had difficulty contacting (or maintaining contact with healthcare providers) a “contact” watermark was given. It also applied in cases where St. John's staff was unable to reach a patient for any reason (e.g. moved from lodging, invalid phone number, co–worker left, or cellphone plan discontinued). For example, a score of 2 was: “Not able to reach patient at phone numbers listed in chart. Patient does not know date of [REDACTED] appointment yet” (excerpt from St. John's Log book). Being unable to maintain contact with a patient can negatively impact the patient's condition, as the patient may not be able to communicate any changes in their condition or receive information about their condition in a timely manner.

2.3.11. Schedule

The “schedule” watermark was applied in cases when the participants were unable to attend an appointment due to conflict between their work schedule and the opening hours of the medical facility. It was also applied if timing of medical appointments was a concern in St. John's logbook, or a reason why a patient missed an appointment. For example, a score of 2 was assigned in this case: “[REDACTED] was unable to attend physiotherapy appointment because work hours were extended”, or “[REDACTED] could not attend [REDACTED] appointment because the medical office's opening hours are in the middle of the day”. Being unable to attend a medical appointment can have a negative impact on patients as it delays care and may increase stress levels.

2.3.12. Employer Impact on Health

If a migrant farmworker explicitly stated that their access to health care was dependent/connected to the supervising employer, then the watermark for “employer impact on health” was added. For example, two migrant workers in ON (who asked that the interview be recorded by notes as they were afraid someone would identify their voice) said that their employer would assess their injuries and decide whether it was warranted for the participants to see a physician. This can impact the patient’s health in a number of ways such as adding stress, delaying care, and reduce a sense of autonomy.

2.3.13. Mental Wellbeing/Mental Health

The “Mental wellbeing/Mental Health” watermark was assigned if a participant self-identified mental wellbeing as a problem (i.e. I did not assign the watermark if I thought the participant was experiencing any mental health difficulties as I am not trained in assessing mental health). When participants identified loneliness and/or anxiety as part of their experience in Canada, the “mental wellbeing” watermark was also noted. A participant in Ontario stated that she had trouble sleeping at night because she was experiencing high levels of stress at work, and that this was affecting her sense of wellbeing.

2.4. Interviews

The same series of open-ended questions was put to all twenty migrant workers interviewed with the intention of allowing workers to discuss the barriers to healthcare in their own terms. Open-ended questions led to in-depth conversations about experiencing illness while in Canada and the steps they did or did not take to seek medical care. Though medical conditions were discussed as part of this work, no medical records are discussed in this study (nor was any medical advice or information given to participants by the researcher). The participants had the option to be audio-recorded, or for their participation to be logged in writing. Participants could also withdraw their participation at any time, knowing their records would be deleted. Migrant workers were contacted through snowball

sample and word of mouth. All of the interviews took place at support centres run by the Agricultural Workers Alliance in BC and ON.

Once all of the interviews were conducted, the barriers or watermarks that migrants referred to were identified, yielding thirteen categories similar to the research conducted by scholars studying this particular field (Otero, Preibish, Hannebry, McLaughlin, and Encalada Grez): transportation, language, finance, culture, fear, institutional knowledge, guilt/imposition, gender, contact, employer impact on health, mental wellbeing, and schedule. All of these barriers appeared in ON and in BC. However, financing medical care was discussed more in BC, whereas concerns with cultural differences were alluded to more often in ON. A further study of these barriers is included after this section.

2.5. Logbook

In order to support patients through the follow-up process, St. John's Clinic keeps a chart that logs in the steps and progress of each case throughout the year. For instance, if a specialist has been informed that the patient has private insurance and therefore asks for a payment upfront, this information is logged in the chart. If the patient is unable to pay upfront, this information is also recorded in the chart. If the patient faces transportation issues in order to get to a medical appointment, the process to reduce this barrier is entered into the chart. A logbook from St. John's clinic was analyzed for this study, and out of 250 patients seen at the clinic, 80 follow-up cases were analyzed for this study. All records pertaining to the patient were erased from the logbook to protect patient confidentiality. The data from the logbook was coded in the same way as the interviews: with a watermark score system designed for this study.

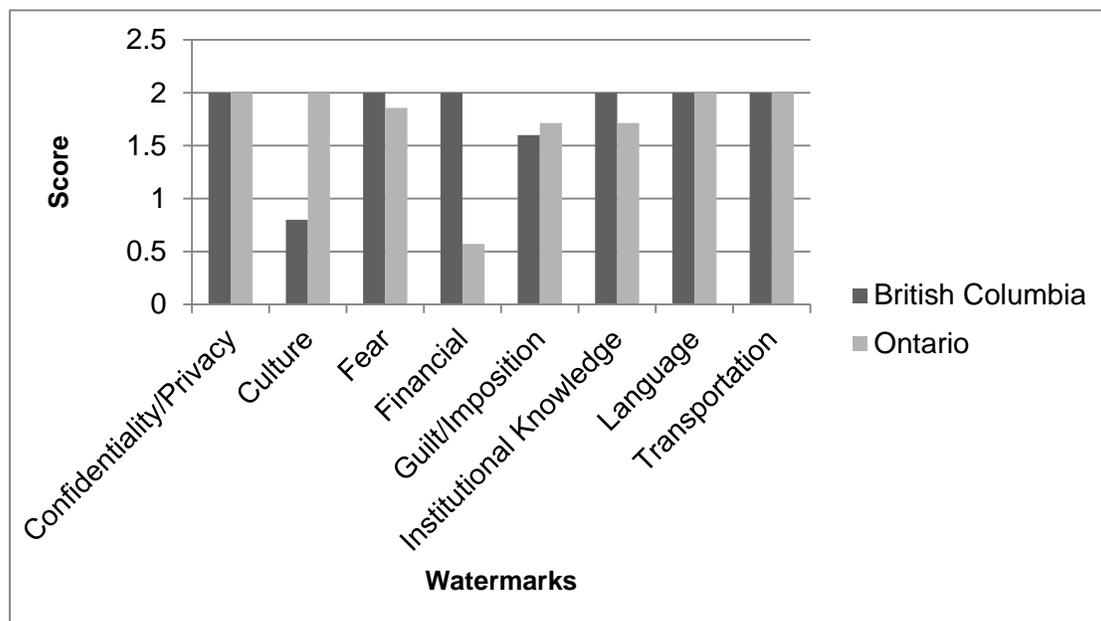
2.6. Interview Data Analysis

After the interviews were coded and watermarks were identified, average scores for each barrier were calculated for ON and BC. These findings are presented in Figure 2.1. Watermarks that were not present in the interviews were not included in the table.

Transportation, Language, and Privacy/Confidentiality yielded a score of 2 both in BC and in ON, meaning that they impacted/influenced access to health care equally in both provinces. Fear was slightly higher in BC than in ON, whereas the sense of Guilt/Imposition was slightly higher in ON. Participants in BC struggled with Institutional Knowledge more than participants in ON.

The largest contrast between both provinces was the financial barrier for a number of reasons; participants in ON are covered by provincial Medicare (OHIP) and by COWAN (private insurance company), which means that they have two options for health care costs to be covered. Moreover, clinics in ON did not ask the patient to pay upfront; rather, they billed the private insurance directly for any procedure/medication that was not covered under the patient's OHIP plan. In BC, migrants have the option to apply for Medical Service Plan (MSP) three months after their arrival, and from the ethnographic data gathered in this study, all medical clinics contacted were unwilling to bill COWAN directly— preferring instead, to ask the participants to pay upfront and for the participants to deal with the reimbursement process on their own. This contrast is congruent with the study conducted by Otero and Preisbisch in BC, which recommended MSP be implemented the same way OHIP is in ON (Otero & Preisbisch, 2015). This could also

Figure 2.1: Watermark score of 20 Interviews



explain why Institutional Knowledge was 0.3 higher in BC than in ON, as participants did not know how to manage the bureaucratic process to get reimbursed.

2.7. Logbook Data

Eighty Logbook charts from 2014 were analyzed in the same way the interviews were – any time a watermark was logged, it was given a score of 0, 1, or 2 depending on the level of impact it had on the patient’s access to timely medical care. It should be noted that there is no data to compare this to as there was not the same access to medical information from other medical clinics, nor is the Logbook a conventional method used by clinics to keep track of records. Numbers closer to 1 are watermarks that did not affect people as strongly as watermarks closer to 2. Therefore, the watermarks that affected migrant workers more in BC are: financial, language, time, and transportation. Nevertheless, the results shown in Table 2.2 are evidence that these watermarks became barriers for many migrant workers needing to access medical services in BC.

Table 2.2: Watermark Results of 80 Logbook cases

Watermark	Average	Sum of Responses
Confidentiality/Privacy	1.20	42
Contact	1.09	38
Culture	1.26	44
Employer Impact on Health	1.37	48
Fear	1.23	43
Financial	1.43	50
Guilt/Imposition	1.09	38
Institutional Knowledge	1.34	47
Language	1.49	52
Mental Health	1.03	36
Sought Medical Care	1.43	50
Time	1.57	55
Transportation	1.43	50

Figure 2.2: Comparison Between Logbook and Joint ON/BC Interview Data

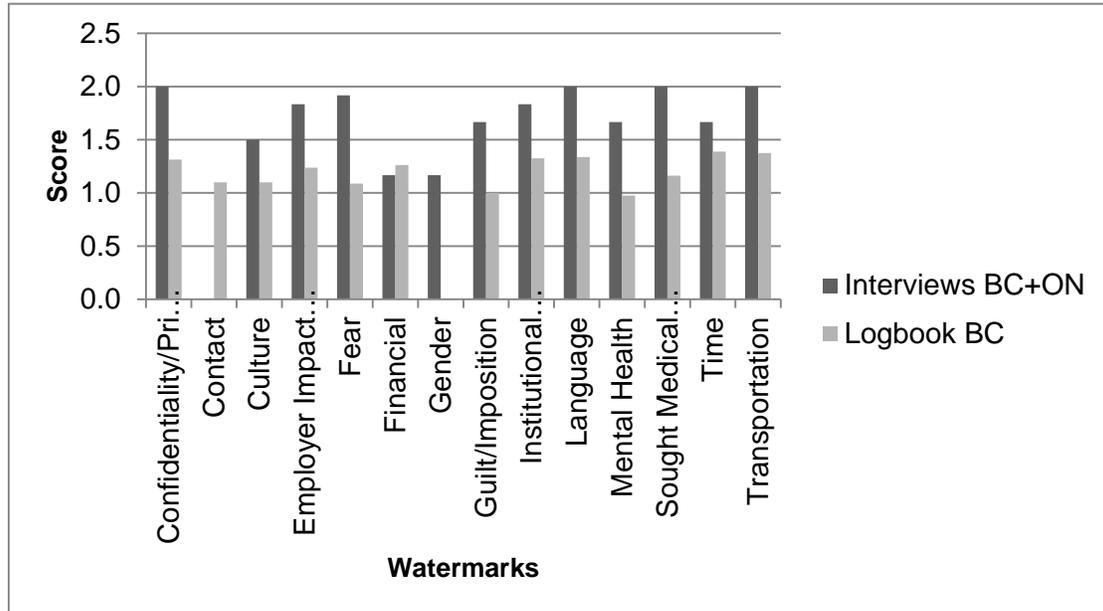


Figure 2.2 shows that in both provinces, all watermarks were present, though it affected migrant workers at differing levels. St. John’s Logbook shows a significant drop in barrier levels. We might conclude that migrants who were not patients of St. John’s encounter these barriers at a higher level. This discrepancy in results could also be because St. John’s has experience in providing medical care to migrant farm workers, and therefore is aware of the barriers they may face. Thus, St. John’s is equipped to address these barriers and attempts to reduce them before the barriers prevent/reduce access to health care.

Table 2.3 establishes the differences between watermarks present in BC and ON. Time, Financial, Sought Medical Care, and Fear were the watermarks with the most discrepancy in barrier level between the Canadian provinces.

Table 2.3: Difference in the Types of Watermarks Affecting both Provinces

Data jump between Logbook cases and interviews	Watermarks
7	Time
7	Financial
6	Sought medical care
6	Fear
4	Mental health
2	Institutional knowledge
2	Guilt/imposition
1	Transportation
1	Confidentiality/privacy
1	Culture
0	Language
0	Employer impact on health
0	Gender

Chapter 3.

Discussion of Findings

In this section, the results of the study above will be discussed by focusing on seven watermarks that yielded higher scores: transportation, language, financial, culture, fear, gender, and schedule. Based on the data presented above and on observational field notes gathered in BC and ON, the watermarks will be further contextualized. Pat Armstrong and Hugh Armstrong succinctly express why it is important to ensure that adequate health care is accessible to all: “it represents our commitment to shared responsibility and our recognition of shared vulnerability” (Armstrong & Armstrong, 2008, p. 8). Currently, Canada is not recognizing the vulnerability of migrant farm workers. Instead, the reinforcement of bureaucratic barriers is preventing migrant farm workers from accessing medical services.

3.1. Transportation

Under the SAWP contract, employers are required to provide transportation to grocery stores once a week. Hence, the clinic in Simcoe, ON, is open during the hours migrant farm workers are in town. Similarly, a not-for-profit medical organization strives to set up pop-up medical clinics on Sunday afternoons or evenings in locations that are already accessed by migrant farm workers. For example, one of their sites is set up on a parking lot of a shop migrant farm workers frequent on Sunday afternoons, and another clinic is set up inside a Church, as the Church organizes vans to bring the workers to Mass once a month on Sunday.

Workers depend on others for transportation to medical services, such as their employer, a support group (church volunteers, union staff, or friends), or taxis. The clinic in Simcoe has addressed these issues by coming up with an agreement with the local Superstore shop to provide a van to transport workers from the centre of town to the clinic located in the same building; this way, migrant farm workers get a ride to the clinic, and the store benefits from their purchasing power. However, workers are still dependent on

their employer for a ride from their housing to the town. While I was there, I saw many school buses parked outside shopping centres and near the centre of town for this purpose.

3.2. Language

In Mexico and Guatemala, farming takes place in rural areas, and as a result, not many of the migrant workers in the SAWP or the Temporary Low Skilled Work Permit groups have had access to a comprehensive level of education, nor had the opportunity to learn English (Preibisch & Binford, 2007). Additionally, there is a prevailing assumption on the part of employers and the medical establishment in BC that migrant farm workers from Mexico and Guatemala are native Spanish speakers. Tanya Basok explains that:

in practice Mexican workers do not exercise several (..) rights. At times they are unaware of their entitlement. Even when they know their rights, they find it extremely difficult to navigate within the Canadian social protection system because they are deprived of the knowledge necessary to access the benefits. Until recently, Mexican workers had very little contact with the host society. Mexican workers were limited in their knowledge of the English language or ways of operating in a new society and thus were virtually denied the knowledge they needed to claim their rights (Basok, 2004, p. 54).

When seeking a doctor at a walk-in clinic or a hospital in BC, migrant farm workers have a difficult time expressing their needs in English. During my ethnographic fieldwork with the St. John's clinic, I realized that for many migrant farm workers Spanish is their second language, as an indigenous language is their mother tongue. Otero and Preibisch found that 54 percent of participants in their survey were speakers of an indigenous language in Mexico (Otero & Preibisch, 2010). If there happens to be someone to translate the conversation from Spanish to English and the patient is indigenous, it makes it even harder for the patient to express what their medical history is and what accurately ails them at the time. This renders the experience of seeking medical attention difficult on two counts; it can make them feel embarrassed about being unable to communicate their needs effectively, and they may be unable to fully understand what the diagnosis, optimal treatment, and prognosis are— which can impact the type of treatment they consent to receive, or the extent to which such consent is properly informed.

In both Canadian provinces, workers expressed frustrations with the fact that they did not speak English, and particularly at the inability and inaccessibility of opportunities to learn the English language in order to become more independent/autonomous. Compounded by the lack of English skills, some workers also struggled with literacy levels in Spanish (two participants in this study learned how to read and write from a co-worker at the farm). Though the SAWP contract requires a primary level of education to have been completed, I observed that a few workers struggled with literacy. The services geared towards migrant farm workers assume that Spanish is the mother tongue, thus it becomes the main language for communication. If workers are having literacy problems and are navigating a secondary or tertiary language, it is concerning whether or not they are fully informed of their rights, obligations, and expression of demands.

3.3. Insurance Coverage: Financial Obstacles

As of December 2012, migrant workers under the SAWP are required to purchase a private insurance before they arrive in BC (Stastna, 2012). Mexican migrant farm workers are required by their government to buy insurance from the COWAN Insurance Group, a subsidiary of Great West Life Insurance Company (General Consulate of Mexico, 2013). COWAN claims to be the biggest private insurance provider in Canada and specializes in servicing the agricultural sector (COWAN Insurance Group Ltd., 2013). The insurance cost is \$0.50 a day, which is deducted from the SAWP migrant farm worker's salary directly by the farm employer (Mexican Consulate General, 2013). Though the amount may not seem high, one should keep in mind that migrant farm workers in BC are paid a minimum wage of \$10.25 per hour for 8-hour work shifts and they are not compensated for overtime (UFCW, 2011). In the case of migrant workers in BC, they may apply to enrol in MSP after three months have passed; most migrant farm workers never do though, as it is more expensive (per consulate officials). In ON, however, workers are covered by OHIP from the first day they land in the province and by COWAN. Thus, Mexican SAWP workers in ON have better comprehensive coverage.

Most SAWP migrant workers in BC do not enrol in MSP because it costs more than COWAN's fee. COWAN's coverage is supposed to provide the same level of coverage as MSP, and in some cases, it covers more (such as physiotherapy and some

medications). Also, the MSP application process can seem daunting and requires the assistance of the employer. Temporary Low Skills Workers, however, are enrolled in MSP but not in COWAN (Justicia for Migrant Workers BC, 2006). This means that migrant farm workers working alongside each other in the field have different forms of health coverage, which generates different conditions when they attempt to access health care services. This difference is not as strong in ON, as all temporary low skilled workers and all SAWP participants (including Jamaicans) are covered by OHIP. Mexican SAWP workers have both OHIP and COWAN and are thus branded as “lucky” by other temporary migrant farm workers from other nations.

The structure of the healthcare system in BC is not only an institutional barrier in and of itself. Also, the policies it implements generate more barriers that constitute structural violence. Seth Holmes explains this concept: “by structural violence, I mean the violence committed by configurations of social inequalities that, in the end, has injurious effects on bodies similar to the violence of a stabbing or shooting” (Holmes, 2013, p. 43). By instituting the policy to decline private insurance and putting the onus of payment on the patient, the BC provincial health agency is effectively denying access to medical care in its hospitals and clinics and thus affecting patient wellbeing. This difference between ON and BC could account for the latter’s higher watermark score: whereas ON’s health care system is able to respond to the medical needs of migrant farm workers by creating programs financed by the provincial health authorities and by accepting COWAN payments, BC has not created any programs to address these gaps, while also implementing a policy that financially prevents/dissuades access to health care. The onus of payment is transferred to the patient, effectively fomenting an institutional set-up for self-selection out of medical care. BC its breaking its responsibility towards a portion of residents in providing adequate access to medical care.

The BC provincial official webpage defines who is eligible to claim MSP coverage:

To qualify for MSP coverage, an individual must be a resident of BC. A resident is a person who:

- is a citizen of Canada or is lawfully admitted to Canada for permanent residence,
- makes his or her home in B.C., and

- is physically present in B.C. for
- at least six months in a calendar year, or
- a shorter prescribed period*,
- and includes a person who is deemed under the regulations to be a resident but does not include a tourist or visitor to BC.

*Note: Effective January 1, 2013, eligible B.C. residents (citizens of Canada or persons who are lawfully admitted to Canada for permanent residence) who are outside B.C. for vacation purposes only, are allowed a total absence of up to seven months in a calendar year.

Certain other individuals, such as some holders of study and/or work permits, or working permits on working holiday programs — which are issued under the federal Immigration and Refugee Protection Act and are valid for a period of six or more months — may be deemed residents. Tourists or visitors to B.C. do not qualify. (BC Ministry of Health, 2013)

Migrant farm workers from Mexico and Guatemala meet the criteria outlined above. Though Guatemalan workers have an easier time accessing their MSP cards (because employers enrol them in the program), Mexican workers do not. In the interviews conducted, many were not aware that they could also apply for provincial coverage, and if they did know, they did not know how to do so. Robert G. Evans points out in his report to the Commission on the Future of Health Care in Canada that:

public health insurance programs are taking up an increasing and unsustainable share of national and/or public revenues and have simply failed to check the fiscal facts. Nor is there any basis for the claim that Canada has reached some absolute limit, for political or economic reasons, in the amount of public money available for health care.(Evans, 2002, p. 42).

According to Evans, then, BC should be able to restructure its medical institutions to address the needs of temporary workers as there is more revenue than expenditure. A few advocates in the field argue (such as volunteers with the AWA) that it is not financially beneficial for workers to enrol in MSP since they would still have to pay COWAN until they leave Canada, and that the number of barriers they experience would not be greatly reduced. The results of this study, however, demonstrate that access to healthcare in BC is more difficult than in ON: migrants' lack of provincial insurance means that workers are asked to pay upfront for medical care. As a result, patients either self-select out of care (either because they are unable to pay, or because they fear the cost of the medical visit),

or the receptionists of medical establishments prevent them from seeing a medical professional without having paid for the visit first.

One of the migrant workers interviewed said he found it disheartening to seek medical attention while in Canada because, in the two years he had participated in the program, each time he was sent to a different province. He found it difficult and intimidating to navigate each province's system. He was particularly confused with the insurance requirement of BC which asked him to pay upfront and later submit a separate claim to COWAN, whereas in ON he had accessed health care through the ON Health Insurance Plan. This man's situation is testament to the confusion migrant farm workers face when seeking medical attention; bureaucratic measures, compounded by language differences, were enough to deter him from seeing a physician. The requirement to pay upfront is, inadvertently or not, a form of denial of access to medical services.

Table 3.1: Comparison of Health Coverage

Program	MSP	OHIP	COWAN
SAWP	<ul style="list-style-type: none"> • Eligible to apply after 3 months • Covers medical visit, tests, and labs • Medications, vision (unless in case of emergency or specialist care), and dental (unless in case of emergency) are not covered 	<ul style="list-style-type: none"> • Part of dental surgery in hospital is covered, regular dentistry is paid by patient • Eye exam once every 12 months for persons aged 20 – 64 who have medical conditions requiring regular eye examinations⁵ • visit to family doctor and specialists • basic and emergency health care services, including surgery and hospital stays. 	<ul style="list-style-type: none"> • Some medication covered • Covers medical appointment, laboratory studies, Xray and imaging covered • Dental and vision in case of emergency
TLSWP	<ul style="list-style-type: none"> • Eligible to apply after 3 months • Covers medical visit and laboratories 	<ul style="list-style-type: none"> • Part of dental surgery in hospital is covered 	

⁵ <http://www.health.gov.on.ca/en/public/publications/ohip/services.aspx>

	<ul style="list-style-type: none"> • Medications are not covered • Tests are covered • Vision and dental is not covered 	<ul style="list-style-type: none"> • Eye exam once every 12 months for persons aged 20 – 64 who have medical conditions requiring regular eye examinations⁶ • visit to family doctor and specialists • basic and emergency health care services, including surgery and hospital stays. 	
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In sum, in BC the insurance that Mexican migrant workers have (COWAN) is supposed to provide the same coverage as MSP (Table 3.1). In this regard, the coverage is mostly the same (COWAN covers a few medications that MSP does not cover). The difference in forms of payment, however, is what causes confusion and also becomes a barrier for migrant farm workers. When a person with MSP coverage seeks medical attention, the medical provider is able to bill the provincial system directly. However, because COWAN is a private insurance company, the worker has to pay upfront. Even though the coverage is the same, the ease of access to services differs greatly and ultimately impacts the worker’s health negatively. This difference does not arise in ON, as workers are covered both by OHIP and COWAN. SAWP workers in ON are also covered by OHIP, whereas in BC they are not immediately covered by MSP. The difference in medical coverage increases the tension between workers; in ON, Mexican workers were perceived to have a “better deal” and an easier time than their Guatemalan counterparts because they had two insurance plans. However, in BC, Mexican workers perceived Guatemalan workers to have an easier time because they did not have to pay upfront for medical visits. Seth Holmes reminds us that: “perhaps instead of blaming the growers, it is more appropriate to understand them as human beings doing the best they can in the midst of an unequal and harsh system” (Holmes, 2013, p. 53). Though growers are connected to the wellbeing of the workers they hire, the provincial government is mandated to provide medical care. Inadvertently, the institutionalized differences are

⁶ <http://www.health.gov.on.ca/en/public/publications/ohip/services.aspx>

affecting the relationship and bonding between workers in farms, which can lead to increased stress as workers further hide their medical needs and resent their coworkers.

3.4. Cultural Differences and Expectations

While Mexican seasonal workers participate in the community life as producers and consumers, until recently they had been insulated from the rest of the community. In Leamington, which receives close to 3000 workers, Mexican workers are highly visible yet (...) very few people take an interest in them. Due to the language barrier, Mexican workers do not attend regular church services. Instead, a Spanish-speaking priest offers them a separate Sunday service at a local Roman Catholic Church. Their cultural celebrations (such as the Mexican Independence Day celebration or Father's Day) draw very few local residents (Basok, 2004, p. 55).

The lack of interaction with the local Canadian community stalls migrant workers' knowledge of where medical facilities are, how they operate, and what the unspoken social rules of behaviour are. The high number of countries participating in the SAWP and in the TLWP has fostered the opportunity for racist attitudes to become instilled in Canada as Canadian farmers can "pick" where their workforce comes from (Preibisch, 2004). Canadian farmers feel more comfortable choosing where their workers come from because it gives them a sense of control over their production process (Preibisch, 2004). Racial stereotypes are reinforced as farmers assign workers from different nations to do work in different areas based on the worker's ethnicity; thus, Jamaicans are sought to work in orchards because of their height, and Mexicans to greenhouses because of their shorter stature and perceived preference for warmer working conditions (Preibisch, 2004). As Amartya Sen states, "the sense of inequality may also erode social cohesion, and some types of inequalities can make it difficult to achieve even efficiency" (Sen, 1999, p. 93). Cultural tensions arise in Canada as migrant workers feel further alienated from the hosting community because they are unable to live and work in Canada without being judged by stereotypical labels (Sook Lee, 2003).

The documentary "El Contrato" catalogues these racist attitudes well; in a scene where a Canadian woman explains what the town does when migrant farm workers misbehave in public, she says "we call their owners and ask them to pick them up" (the "owner" being the Canadian employer) (Sook Lee, 2003). Migrant workers are aware of

racial stereotypes that they can fall under. As a result, racism acts as a barrier when they seek medical attention because they do not want to be judged by the medical professional attending them, or affect the perception their employer has and thus exacerbate their working/living context in Canada. Cultural differences and awareness are crucial in a medical setting, more so in the case of a migratory population. Continuity of care hinges on physician's notes being carried across borders (not always possible), with the hope that all parties deem the type of treatment suitable involved. Also, the expectations of the patient-physician relationship can vary- this variation can impact the course of treatment the patient receives, as there is a chance the physician and the patient is (un)aware of particular social cues (for example, the way a medical exam is conducted, or how a question is asked to or by a medical professional).

3.5. Fear

Fear is an immense barrier for migrant farm workers: fear of loss of employment, and of being perceived and branded as problematic. If labeled as unfit, then there is a high chance for the worker to be removed from the program. This would result in the loss of a significant source of income for the worker's family in Mexico. A civil society member who supports migrant workers shared that this fear can also lead to the usage of fake identities when attempting to access medical services so as to protect anonymity. Additionally, there is fear about receiving health care in Canada. Confusion over the different types of insurance programs and "appropriate" interaction with the physician also has a great impact on the decision to seek health care. It is common for workers to share medications and suggest natural remedies, which can hinder the health of the patients as they lack the medical expertise. Fear can lead to self-medication.

3.6. Gender

There are fewer numbers of women working in Canadian fields, which can lead to their being stigmatized simply by gender(Sachs & Alston, 2010). This focus has distorted the perception of migrant women's role in agriculture in Canada– withholding the agency exercised by women whilst also entrenching the patriarchal structures of the agricultural

sector. Women's labour is perceived, therefore, as solely tied to the existence of an extreme need for them to support their families rather than a desire, or competence, to work in the agricultural sector.

Only two women were interviewed for this study. No women were interviewed in BC, though both women interviewed in ON had worked in different parts of BC previously. Both of them expressed concern about being safe from sexual harassment at work, a concern none of the men interviewed raised. Moreover, they cited barriers in ON that other participants did not— such as financial costs of health care, and the fact that they were locked in their housing facility at night. The fact that after a semester doing fieldwork I was unable to meet any women in BC, and that none of the organizations I spoke with was able to maintain contact with any migrant women workers, is indicative of the type of isolation this particular demographic faces, or the low number of women that are part of the program.

Until 1998, only Mexican single mothers were allowed to partake in the SAWP program in Canada (UFCW, 2011). Women TMWs are sought after because of the ties that bind them to return to Mexico (their children). Women TMWs are sought after because of the ties that bind them to return to Mexico (their children). Migrant women's ability to reproduce is seen as a threat to the tight valve of migration (Preibisch, 2004); the SAWP is not implemented in order to seek immigrants to increase the Canadian population, but to bolster the Canadian economy without expanding it.

Kerry Preibisch (2004) argues that the Canadian state prefers women that are already mothers because it means they will not want to prolong their stay in Canada beyond their working contract— or that women are not likely to reproduce on Canadian soil as their partners are at home. Women have had to undergo pregnancy tests before boarding the planes to Canada (Preibisch & Encalada Grez, 2010), and in one case where the foreman found out about a pregnancy, the expecting migrant was quickly boarded on the next plane back to Mexico (Preibisch & Encalada Grez, 2010). The pregnancy-test practice demonstrates the gendered treatment of migrant workers. The Canadian state gives farmers the right to repatriate a worker without a clear set of guidelines as to what a valid reason for repatriation is (Preibisch, 2004). By giving farmers the power to decide

when repatriation can take place, the state is perpetuating patriarchal structures: Canadian farmers can decide the status of female workers based on the health of the migrant.

Gender roles can be deeply segregated in rural areas of Mexico (Preibisch & Encalada Grez, 2010). According to Mexican migrant workers interviewed by Preibisch and Encalada Grez, women are marked and segregated if they actively seek employment in Mexico (Preibisch & Encalada Grez, 2010). Female migrant workers from rural Mexico claim that they are from a patriarchal society: men are obliged to provide for their family and are responsible for their wellbeing. A woman's duties are perceived to be caring for her husband, performing domestic tasks, and raising children (Preibisch & Encalada Grez, 2010). Indeed, the Mexican wives of SAWP workers judge migrant female workers and mark them as potential home-wreckers (Preibisch & Encalada Grez, 2010). In connection to these cultural customs, Mexican women that are enrolled in, or seeking to be part of, SAWP face a range of obstacles: they are racialized, alienated in their societies, and are subjected to sexual harassment (Preibisch & Encalada Grez, 2010).

Kerry Preibisch and Evelyn Encalada Grez frame the female migrant experience as one where migrants' experience of the SAWP extends to a series of areas: personal, social, and familial. The rendition of the migrant women interviewed can be distilled to the following: after the many obstacles they had to overcome once they reached Canada, they were willing to accept any working conditions (Preibisch & Encalada Grez, 2010)—thus proving that they are resilient. Some women are aware of how precarious their situation is, and do not hesitate to expose fellow workers that breach the rules to the foremen—especially if women are engaging in romantic relationships (Preibisch & Encalada Grez, 2010). Their experience of transnational motherhood is exacerbated by the fact that they work in a sector that is physically demanding, and socially exclusive; migrant women have to regulate their behaviour at all times or risk losing their jobs because of gossip or negative perceptions of their sexual behaviour. As a result, migrant women in Canada experience a great deal of stress because they are fearful of transgressing Mexican and Canadian sociocultural norms.

Though the medical clinic in BC provides services to all genders, no women attended the clinic during the period where the field study was carried out. The farms where women work are further away than the radius St. John's covers. When I spoke with local Church groups about their connection to migrant women workers, they expressed frustration at being unable to reach them because of the distances to the farms and the lack of interest on behalf of employers to allow the women to attend church.

3.7. Schedule

Walk-in clinics and other medical services generally follow conventional business hours, and are therefore closed after 4:30pm and on Sundays. Incompatibility of schedule is not only a barrier for seeing a physician, but also when needing to complete medical tests or attend other medical therapies; physiotherapists, X-ray clinics, and laboratories are rarely open on Sundays.

This means that workers have to ask for a day off and arrange transportation to get a medical test done. Some argue that this is an inconvenience the average Canadian resident has to undergo but this barrier quickly grows for migrant farm workers due to the language barrier, and a lack of "institutional knowledge" of what steps must be taken to book such medical services. In Leamington (ON) for instance, both the nurse practitioner and walk-in clinic physicians interviewed were aware of the work schedule of migrant farm workers and the difficulty/frustration patients had when attempting to access health services. Both practitioners in Leamington had made a conscious effort to open their practices at a later time and on weekends.

Chapter 4.

Conclusion

As discussed in the Literature Review, research on migrant farm worker's access to health care services is limited. Scholars have analyzed the impact NAFTA has had on migration pattern, as well as the working and living conditions migrant farm workers under the SAWP and TMP face. In comparison to migrant workers in other industries in Canada, migrant farm workers experience unique sets of barriers that hinder access to healthcare.

However, the number of studies focusing on migrant farm worker's health and health related issues are not up to par with other disciplines affecting this population group. In this study, indicators were compared between BC and ON through three different types of data. Thirteen barriers were identified in this study: transportation, language, financial, culture, fear, lack of institutional knowledge, confidentiality/privacy, guilt/imposition, gender, contact, schedule, employer impact on health, and mental wellbeing. Participants in both provinces identified confidentiality, language, and transportation as barriers affecting access to healthcare. In ON, the watermark for "culture" was higher than in BC. Overall, participants in ON identified fewer healthcare barriers than participants in BC when seeking medical care. In BC, the financial watermark was discovered to impact access to healthcare more than in ON. One reason may be because the private health insurance is not billed directly by the health care provider. Overall, 6 out of 13 watermarks affected migrant farmworkers across the board. These were: lack of access to transportation, lack of interpretation services, a difficult payment system, cultural differences, fear for the impact that accessing health care can have on employment, and scheduling difficulties. When combined, these watermarks increased the chance that patients would self-select out of care, reduce access to healthcare, and raised the risk for medical conditions to worsen.

Migrant farm workers experience health inequalities because they have difficulty accessing transportation to hospitals as well as being unable to seek medical care in a private context. Migrant workers' lives while in Canada are fraught with a series of stressors: they experience racism, have trouble communicating their needs, and are

subjected to disparate gender norms. These stressors act as barriers when migrant farm workers seek medical attention because they do not understand how the system works, are alienated culturally and physically from medical centres, and are afraid to draw attention to themselves. The structural setting of health care organized by BC lacks awareness and understanding of migrant farm workers' contract and living conditions—effectively acting as a social determinant barrier to medical care.

Historically, ON was the first province to pilot the SAWP program. Therefore, health care providers interviewed in ON were more aware of and had more experience dealing with the barriers and limitations migrant farm workers experienced when seeking medical care; they made a deliberate effort to accommodate their needs and tailored treatment accordingly. In BC however, the walk-in clinics and hospitals lacked awareness of these difficulties, often saying that it was not their responsibility to adapt or provide alternative methods of health care access. Front desk staffs effectively become gatekeepers; by being the first point of contact, they influence the billing process and the creation of a medical appointment. As a result, migrant farm workers end up self-selecting out of seeking medical attention out of fear of high costs and potential loss of work. Though the provincial institutions ensure that billing is done on behalf of MSP patients, they do not do this for private medical companies. The payment responsibility falls on the patient's shoulders, which impacts access to care. This double standard is preventing BC in fulfilling Canada's health care charter.

It is difficult to ascertain how many Temporary Migrant Workers are currently in BC, as assertions made by the press and migrant support groups vary (given that the need for workers fluctuates). In 2016, the Mexican Consulate claimed there were 5 000 SAWP workers. The lack of clarity on the number of temporary foreign workers present in BC at any one time makes it difficult to calculate how many medical services should be in place in any given area so as to ensure migrant farm workers get the care they need. The BC Federation of Labour claims that as of 2011, there were over 70,000 Temporary Migrant Workers (BCFED, 2012)—a number that is quite high, especially when compared to the number of patients (280 patients) seen in 2014 by St. John's Clinic.

From the findings in this research project, I recommend that future studies on this topic consider exploring how migrant farm workers in other provinces are accessing health care services. Though the nature of this study is mostly qualitative, efforts were made to quantify the emotional and bureaucratic journey migrant farm workers faced when attempting to access medical care. Further studies with a larger sample size documenting this experience are needed. Moreover, institutional ethnographic studies exploring migrant farm workers' access to healthcare should take place in hospitals and at walk-in clinics.

BC's provincial health authorities should start addressing the lack of medical care provided to migrant farm workers. As of 2016, BC was not adequately meeting the health care needs of a population group that falls under its mandate. Health care providers across Canada should also ensure that migrant workers are aware of interpretation services offered at hospitals without the third party present in the room. This would reduce the privacy/confidentiality concern all participants in this study had, while also safekeeping a patient's employability (to a certain extent). Moreover, BC should follow ON's lead to create a public health structure that is part of the solution, rather than exacerbate an already precarious situation. Furthermore, WorkSafeBC and Safe at Work ON need to better educate case agents on the realities temporary migrant farm workers face. The system's ability to respond to its community members' needs is crucial if Canada is to offer its workers homogeneous access to health care.

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Appendix A.

Interview Questions for Migrant Farm Workers

Background of Experience with Accessing Health Care

What has your experience in Canada been like when needing to access health care?

When did you realize you needed medical attention?

What were the steps you took to access medical care?

Who participated in this process?

Are you familiar with the St. Joseph's Clinic?

How did you hear about it? Have you attended this clinic before?

Has the process changed since you first wanted access to health care?

How do you finance access to health care?

Have you had any difficulties in accessing these services? Which ones have they been?

How have you dealt with these difficulties?

What helps you access health care?

What prevents you from accessing health care?

Services

Please describe the services you have accessed so far.

Who helped you access these services, if at all?

What mechanisms do you have to reach health care?

How do you choose which services to seek?

Who provides them to you?

Of everything we have talked about, what is the most important for you?

Is there anything we have not talked about that you think is important?

Preguntas Generales para Trabajadores Migrantes

Por favor cuénteme sobre su experiencia al tratar de acceder a la atención médica.

¿Cómo ha sido su experiencia acá en Canadá?

- ¿Cuándo se dio cuenta que necesitaba atención médica?
- ¿Cuál fue el proceso que siguió para poder ver al médico?
- ¿Lo ayudó alguien en este proceso?
- ¿Ha escuchado de la Clínica St. Joseph?
- ¿Cómo supo que existía esta clínica? ¿Ha venido antes acá?
- ¿Cuántas etapas ha pasado para resolver su problema? ¿Por cuánto tiempo?
- ¿Cómo cubrió los gastos médicos?
- ¿Qué dificultades tuvo mientras trataba de acceder a estos servicios médicos?
- ¿Cómo resolvió estas dificultades?
- ¿Qué es lo que le ha ayudado a acceder a la atención médica?
- ¿Qué aspectos le impiden o dificultan acceder a la atención médica?

Servicios

- ¿Cuáles son los servicios médicos a los que ya ha tenido acceso?
- ¿Alguien lo ayudó en este proceso?
- ¿Qué mecanismos usa para acceder a los servicios de salud?
- ¿Cómo escoge los servicios médicos?
- ¿Quién le provee los servicios médicos?
- ¿De lo que hemos hablado hasta ahorita, ¿cuáles son, en su opinión, los temas más importantes? ¿Hay algún otro tema que quiera discutir?