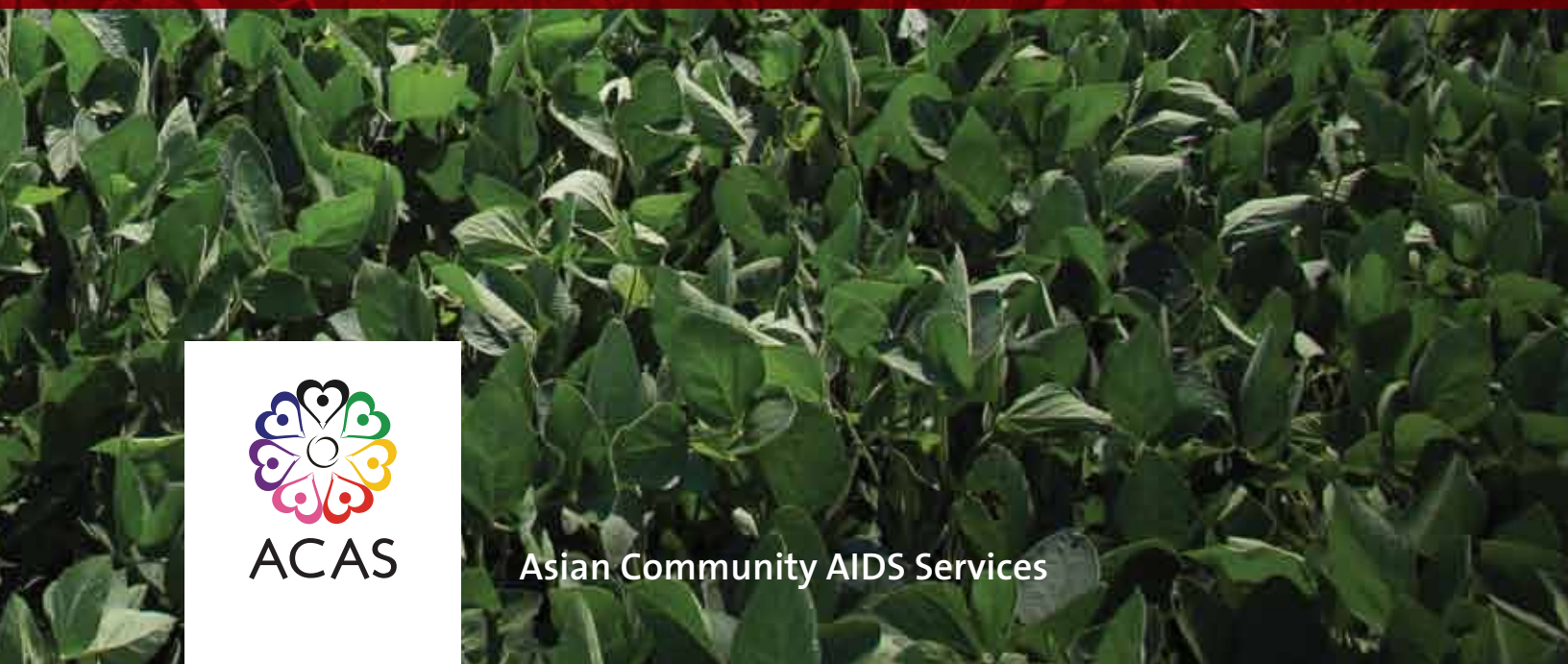
A COMMUNITY REPORT

A Community-based Research Study

ASIAN MIGRANT FARM WORKERS IN ONTARIO:
HIV Knowledge, Sexual Practices and Health Care Utilization



ACAS

Asian Community AIDS Services

EXECUTIVE SUMMARY

Asian Community AIDS Services (ACAS) conducted a community-based research (CBR) study to investigate individual and structural determinants that put Asian Migrant Farm Workers (AMFWs) in Ontario at risk of HIV/STIs infection. Research activities included enhancing the research team's CBR capacity, a cross-sectional survey and follow-up focus groups to explore AMFWs vulnerability to HIV/STIs, barriers to accessing HIV/STI prevention, and protective factors that reduce HIV risks. 100 Asian migrant farm workers from Thailand and the Philippines answered the survey questionnaire and 24 of them participated in the three focus groups.

The majority age group (46%) of 53 men and 47 women who participated in the study is 30-39 years of age. Half of them work more than 40 hours per week. One-third (30%) of participants reported their physical health declined significantly since arriving in Canada. More than a third (38%) reported their mental health as poorer or fair. 16% of participants started using tobacco, and 35% began drinking alcohol since their arrival in Canada.

AMFWs had a moderate knowledge about HIV/AIDS. 62% were sexually active in the past year and 55% of them had sex with a regular partner. Use of condoms was relatively low, with over 76% indicating they rarely or never used condoms with regular partners. 22% reported having difficulty negotiating safe-sex practices with partners. 4% were tested for HIV, 3% for STIs and 4% for both HIV and STIs. Structural issues contributing to their low use of health services included: limited English proficiency and social support; transportation problems; and long working hours.

Focus group participants discussed perceived risks and fear of being infected with HIV/STIs, particularly with a casual partner. The majority assumed sexual partners from the same country were free from HIV because they passed the pre-departure medical screening required for a work visa in Canada. Condom use was mainly for preventing pregnancy. All participants considered sexual health issues private and did not necessarily discuss the matters with co-workers.

We concluded that access to culturally and linguistically appropriate information on health (sexual and general) and health services, as well as labour rights information, would increase their overall health and well being. AMFWs also recommended such activities as having a sexual health discussion among peers and an annual physical checkup for all workers.

Knowledge gained from this study was used to inform policy and HIV prevention practice through meaningful engagement of AMFWs, community stakeholders, and policy makers in knowledge translation and exchange. Two community forums, one for AMFWs and another for service providers, were held to disseminate the findings.

WE WOULD LIKE TO THANK

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For sharing their time, comments to help us gain a better understanding of their living conditions, sexual behaviours and knowledge.

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- Justice for Migrant Workers

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The Research Team
Principal Investigator
- Noulmook Sutdhibhasilp,
  Asian Community AIDS Services

Co-Principal Investigators
- Maurice Poon, York University
- Chris Ramsaroop,
  Justice for Migrant Workers
- Mandana Vahabi, Ryerson University

Co-Investigators
- Grogorgina Binohland-Bahiwal,
  Community Member
- Constantine Cabarios,
  Asian Community AIDS Services
- Evelyn V. Encalada,
  Justice for Migrant Workers
- Piyarat Lek van Koeverden,
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- Miya Narushima, Brock University
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About **Asian Community AIDS Services (ACAS)**

Asian Community AIDS Services (ACAS) is a charitable, non-profit, community-based organization located in Toronto, Canada. We provide safer sex education and services to the East and Southeast Asian communities and support services to persons living with HIV/AIDS and members of the LGBTQ communities.

From 2009-2012, ACAS implemented the Asian Migrant Farm Workers' Health Promotion project to provide HIV/STIs and Hepatitis C prevention, education, and outreach to Asian migrant farm workers in Ontario. Our project partners were the AIDS Committee of Windsor, AIDS Niagara, the Thai Society of Ontario, and Justice for Migrant Workers. We were able to outreach to over 500 AMFWs during the 3 year period. At present, ACAS continues to work with AMFWs by organizing outreach activities, and referral service.

ACAS

Asian Community AIDS Services
Supporting Our Community, Caring For Our Future

260 Spadina Ave., #410
Toronto, ON M5T 2E4
Toll Free: **1-877-630-2227**
Tel: (416) 963-4300
Fax: (416) 963-4371
website: **acas.org**

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Published by Asian Community AIDS Services (ACAS)
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ABBREVIATION

ACAS	Asian Community AIDS Services
AIDS	Acquired immune deficiency syndrome
AMFW	Asian migrant farm worker
CBR	Community-based Research
ESDC	Employment and Social Development Canada (ESDC)
HIV	Human immunodeficiency virus
HRSDC	Department of Human Resources and Skills Development
LMIA	Labour Market Impact Assessment
LMO	Labour market opinion
LSWP	Low-Skilled Workers Program
MFW	Migrant farm worker
PRA	Peer research assistant
SAWP	Seasonal Agricultural Workers Program
STIs	Sexually transmitted infections

LIST OF FIGURES

In 2002, in response to perceived labour shortages in Canada, the Canadian government started the *Low Skilled Workers Program* (LSWP), which allows single employers to directly recruit or use private brokers to recruit foreign workers to fill 'lower skilled' jobs in agriculture, hospitality, construction and other jobs as specified by Human Resources and Social Development of Canada (HRSDC) to work in Canada for up to four years (HRSDC, 2008). These foreign workers can stay to work in Canada for up to four years and must reside in their home country for at least four years before applying for a new work permit[1].

In 2012, Employment and Social Development Canada (ESDC) issued 7,680 Labour Market Opinions (LMO) confirmations to temporary foreign workers under the Agricultural Stream, mostly in low-skilled occupations. Of these confirmations, 1,340 LMOs were issued for jobs in Ontario (ESDC, 2014). These temporary foreign workers are primarily hired to fill jobs like fruit and vegetable harvesting, general farm work, or food, beverage and tobacco processing (Global Workers Justice Alliance, 2010). Most of the MFWs have been steadily coming from countries like Thailand, the Philippines and Guatemala (McLaughlin, 2010) and the newest group of MFWs is from Indonesia.

The LSWP workers are reported more vulnerable than Canadian workers in many ways, and do not enjoy the same level of social protection as Canadian counterparts. The most common problem workers face is excessive recruitment fees that private employment agencies charge. Another structural problem is their closed work permits, which are valid with a single employer, limit their ability to change employers if the working conditions or treatment from employers are unfavourable. It also disproportionately gives power to employers over workers. Many avoid making complaints about wages and working conditions for fear of losing their jobs and work permits.

It is difficult to estimate the total number of Asian migrant farm workers (AMFWs) in Ontario because new workers arrive every year to find work while small number of them move around to different workplaces in southern Ontario. However, through various outreach initiatives, ACAS staff came into contact with over 500 AMFWs who self-identify as Thai or Filipino. The average gender ratio of AMFWs is 60% male to 40% female. Many of the AMFWs contacted in these community outreach activities expressed concerns about their overall health and worker exploitation (ACAS, 2011b).

1 *In June 2014, the Federal Government introduced new measures for foreign workers and their employers. Under the new rules, there are only "High-wage" or "Low-Wage" workers, "Primary Agricultural Stream" including SAWP workers, and workers in the "Live-In Caregiver Program" (Citizenship and Immigration Canada, 2014). Effective April 2015 the Federal Government announced it will lower this 4 year time limit, but they have not yet set the new time limit.*

LITERATURE REVIEW

Studies in the U.S.A. and Canada have shown that MFWs are vulnerable to various health concerns such as occupational hazards and injury, mental health issues, sexual and reproductive health issues, and chronic and infectious diseases such as HIV and tuberculosis. The most recent studies of the health status of migrant workers in Canada found that while they arrive 'healthy' as indicated during pre-departure medical screening, their health status deteriorates during their stay in Canada due to working and living conditions (Preibisch & Hennebry, 2011; Pysklywee, McLaughlin, Tew, & Haines, 2011).

Research evidence suggests that after arriving here, the health of MFWs is impacted by many structural factors such as working conditions (e.g. inadequate training, injuries from farm equipment, exposure to pesticides, repetitive muscle injuries, long work hours); living conditions (e.g. overcrowded/poor housing, unhealthy diet); gender (e.g. female sexual harassment at the workplace, limited access to reproductive health information and tools, and overall safety); health care and health literacy (e.g. limited access due to language and cultural barriers, lack of transportation in remote areas); income and distribution (e.g. seasonal irregular work with low hourly wages, high broker fees to enter Canada); social exclusion (e.g. adjustment to a rural host community, racism, lack of social support) and employment insecurity (e.g. sole power of employers to renew workers' contracts or send them home when injured or sick, lack of power of workers to choose employers) (McLaughlin, 2010; Preibisch, 2007).

There is a paucity of information regarding what MFWs know about HIV/AIDS and their sexual practices. A number of U.S. studies have shown that some Latino and Asian MFWs are vulnerable to HIV/STI risks, and that the fear of job loss, discrimination and stigma often prevent workers from seeking HIV testing and treatment (Hovey, Booker, & Seligman, 2007). Other studies found that risky behaviours (i.e. unprotected sex with multiple partners or sex workers) occurred despite some knowledge of HIV/STI transmission (Fernandez, et al., 2007; UNIDOS, 2004; New York State Department of Health, 2007). Similarly, in a study of Mexican workers who came through the Seasonal Agricultural Worker Program (SAWP)[2] in Canada, McLaughlin (2009) found that issues related to sexual and reproductive health were identified as one of the workers' main concerns. McLaughlin further discovered that SAWP workers have tested positive for STIs such as chlamydia, gonorrhea, HIV and HPV. In addition, female MFWs have reported sexual harassment, unwanted sexual relationships and unwanted pregnancies (McLaughlin, 2009; ACAS, 2011a).

At present, HIV surveillance reports in Canada do not provide information on MFWs. However, there are some reported HIV positive cases among MFWs. For example, in 2007 a 29-year-old female migrant farm worker from Mexico was diagnosed as HIV-positive. She had arrived in Canada merely six weeks prior and had begun work at an orchard. (Srigley, Cutz, Young, Morris, 2007). In 2014, public health referred a newly HIV diagnosed MFW to ACAS to access support services. These cases point to an urgent and critical need of HIV prevention among MFWs.

2 *Started in 1996, the SAWP operate under bilateral agreements between Canada, Mexico, Jamaica and 11 other Caribbean countries. SAWP workers are recruited by the governments of the sending countries with the guarantee of agricultural work from single employers, for up to 8 months.*

ACAS PILOT STUDY

In 2007, two Thai migrant farm workers died in Blenheim and St. Catharines, Ontario, and police were unable to determine the exact cause of death[3]. This prompted members of the Thai community and ACAS to respond by finding ways to provide social and health services to this migrant group.

In 2008, ACAS conducted a pilot study with 20 females and 18 males to explore the HIV prevention program needs of Thai MFWs in the St. Catharines and Leamington Ontario by using a survey questionnaire (ACAS, 2008). The results indicated that these Thai MFWs faced similar challenges as the ones found in the aforementioned studies. 55% of the workers reported that they had never used health care services in Ontario due to a language barrier. Almost 50% of MFWs reported developing chronic health problems such as stomach aches, headaches, back pain, and allergies stemming from exposure to detrimental working conditions (e.g. chemicals and long working hours). In terms of sexual health, 39% reported that they were sexually active in the past 6 months and had one sexual partner. Although the Thai MFWs reported they had some knowledge about HIV/AIDS/STIs (79%) and safer sex practices (66%), about 45% of those who were sexually active never used condoms with their sexual partners, and 27% used condoms occasionally. However, 42% of respondents indicated that they would like to receive information about HIV/AIDS.

Between 2009 and 2012, ACAS staff in the HIV/STI/Hepatitis C prevention program for AMFWs witnessed first-hand and anecdotally, the living conditions of AMFWs. In these three years, we received numerous phone calls and verbal complaints from the workers about stress. A few women requested information about pre-natal clinics and other services. Thai workers also requested an interpreting service for their doctor visits, Pap smear and STI tests. Some had a problem renewing their OHIP cards when their work permits expired.

In terms of living and working conditions, we came across a group of female workers who were made to stay in an overcrowded house, and a few women reported that they were sexually harassed by their employer. At least two Thai MFWs that we know of received serious injuries from work. One MFW lost his arm and was repatriated to Thailand. A few workers had chemical allergies, with two workers losing their fingernails due to the chemicals used at a mushroom farm. Those working in chicken farms reported injury from repetitive strain and heavy lifting. It was also reported that some Thai workers were using methamphetamine and energy drinks to stay awake at a workplace where remuneration was paid by a quota system.

3 *For further details on the death of Thai MFWs, see Randy Richmond's article: Second farm worker died in Ontario: Available online at: http://cnews.canoe.ca/CNEWS/Canada/2007/04/25/4128223-sun.html*

Though we were able to collect basic information on health, HIV and the sexual health vulnerabilities of AMFWs in Ontario, we found that the information we gathered was rather limited. The lack of research resources restricted the ability of ACAS staff to systematically capture and document the experiences and health challenges among AMFWs.

LATEST STUDY

In September 2011, ACAS received a community seed grant from the Ontario HIV Treatment Network to explore the sexual health and HIV prevention needs of Asian migrant farm workers in southern Ontario. The objectives of the study were:

1) To explore Asian migrant farm workers' HIV/AIDS knowledge and sexual behaviours;
2) To identify the personal and structural determinants of HIV and STI vulnerabilities among AMFWs; and
3) To identify individual and collective resilience factors which reduce HIV and STI vulnerabilities.

METHODOLOGY

(i) Theoretical Framework

The principles of community empowerment and capacity-building guided this study, whereby we engaged affected stakeholders (migrant farm workers, advocates, service providers) and researchers to work collectively to achieve the project objectives. ACAS as a lead organization of the study worked in partnership with:

- Community leaders from the Thai and Filipino communities, including migrant farm workers
- Justice for Migrant Workers
- The Thai Society of Ontario
- Academic researchers from Brock, Ryerson, and York universities

As part of community capacity-building, the project trained 4 Thai and 1 Filipino peer research assistants (PRAs) who are current or former migrant farm workers to do outreach to potential participants, and to engage in research activities at all stages of the project, including participant recruitment, data collection, data analysis/interpretation, and result dissemination. During the fall of 2012, a training session was conducted in Leamington, Ontario covering five topics: 1. Basic principles of community-based research; 2. How to recruit participants; 3. How to administer a survey questionnaire; 4. Focus group method; and 5. Consent and confidentiality. The training for Thai PRAs was conducted in Thai and in English for the Filipino PRA. The PRAs were instrumental in recruiting participants, assisting us in administering a survey questionnaire and focus group discussions, and disseminating the research findings by organizing a community forum for AMFWs in the Leamington area.

(ii) Design

A cross-sectional, mixed-methods study design was used to explore HIV/STI knowledge and the sexual behaviours of Asian (Thai and Filipino) MFWs who work in southwestern Ontario and the Greater Toronto Area. It also examined personal and structural determinants of vulnerability to HIV/STI among this population and their perceived barriers in accessing relevant sexual health information and services, and their sexual health information needs.

(iii) Participation criteria

Study participation criteria included: self-identifying as Thai or Filipino; being 18 years of age or older; working and residing in southern Ontario or the Greater Toronto Area; having temporarily migrated to Canada from 2006-2012 through the LSWP; and the ability to understand and converse in Thai or English, based on self-report. A purposive sampling method was used to recruit 100 participants.

(iv) Data collection

Data was collected through a self-completed questionnaire and focus groups, during the period from November 2012 to January 2013. The self-completed questionnaire included three components:

(1) Socio-demographic characteristics and the physical and mental health of the participant: e.g. age, sex, marital status, education, average monthly household income, length of stay in Canada, knowledge of official languages, self-reported physical and mental health, and personal history of health problems and sexual practices. These questions were adapted from questionnaires developed by Statistics Canada in the Census of Population (2006) and from the Canadian Community Health Survey (2010);
(2) Participants' knowledge of HIV/AIDS using the survey questionnaire developed by Ford and colleagues (2001) in their study with migrant farm workers; and
(3) Open-ended questions capturing participants' perceived barriers in accessing sexual health information and services, and their sexual health information needs.

The study questionnaire was translated into Thai by two independent translators. Two versions of the draft translation were compared and adjusted to ensure the accuracy of the translation. Since most Filipino migrants speak English, the questionnaire was administered in English for this group.

The questionnaires were tested for flow, clarity, and comprehension through face-to-face interviews with 10 migrant workers: 5 from Thailand and 5 from the Philippines. The study protocol was approved by the research ethics boards of Ryerson, York and Brock universities. Each participant received an honorarium of $50 for their participation in the study.

In addition to the self-completed questionnaire, three focus groups were conducted, two with 8 female Thai participants and 8 male Thai participants, and the other with 8 Filipino participants, in order to explore the participants' experiences working and living in Canada; what helped and/or hindered them in accessing sexual health care; and their perspectives on sexual health issues. The two Thai focus groups were conducted in the participants' mother tongue; the Filipino focus group was conducted in English.

FINDINGS

(i) Participants

A total of 100 Thai and Filipino migrant farm workers participated in this study. The average age of participants was 38 years, with ages ranging from 20 to 50 years. Slightly more than half of the participants (53%) were male, and the majority (80%) of participants were from Thailand. Of our participants, 61% were married or in common law relationships, with 83% having children, although a majority (80%) did not have their children living with them in Canada. Approximately half (47%) of participants had an education level of grade 9 or lower, with roughly two thirds (69%) having limited English proficiency, and 6% could not speak, read or understand English at all. Approximately one third (34%) of the participants lived in Canada for less than one year.

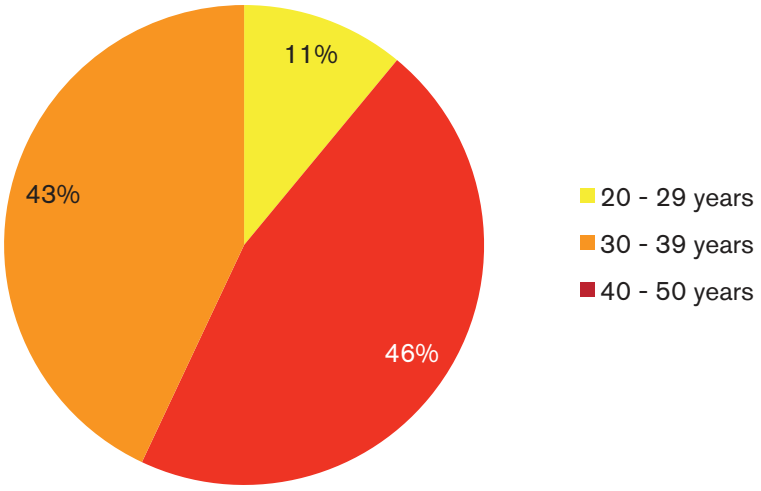

Figure 1: Age Group

(ii) Working and Living Conditions

About 86% of participants were employed full-time, but a majority of them lived below the Canadian after-tax income cut-off point (76% reported an average after tax monthly income of less than $1,999 and of those, 10% had an income of less than $1000). Approximately half of the participants (48%) worked more than 40 hours per week.

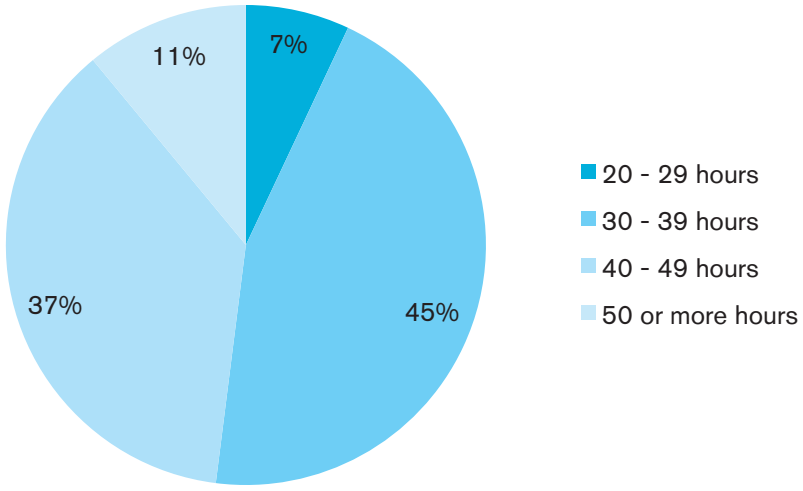

Figure 2: Work hours

The majority of participants (71%) lived in a house, while 21% lived in an apartment. When they first arrived in Canada, they usually stayed at accommodation arranged by employers. Rent, and in some cases a cleaning fee, are deducted from their paycheques. Once workers become familiar with the town and have made new friends, they may decide to move out and rent their own place. The most common household size was 5 - 9 people (55%). 21% of households had 10 or more people residing together, and only 20% had 1- 4 people in a household. Concerns regarding household living conditions included: inadequate heating, faulty electrical appliances, no exhaust fan, inoperative stove, unusable washing machine, faulty water faucets, cleanliness/hygiene, insufficient living area, and problems with roommates. Nearly three-quarters of participants shared their sleeping area/bedroom with other people, and of those, 56% shared with 1 – 2 people, while 29% shared with 3–5, and 12% shared with 6 or more people.

Participants further elaborated their concerns regarding their living conditions in the focus groups. For example, one Filipino female worker who lived in a house arranged by her employer said,

> *We live there like 10 or 11 persons in 1 house just having 2 washrooms, you know the bathroom, so hard for us and then there's the time that winter came and we're having a problem with the heater, since we live there like 10 persons, we having the same shift, work in the same shift like having to take a bath at the same time. For example in the morning, all of us have to take a bath in the morning. So we're running out of heater or hot water and especially during the night, it's so cold because we only have heater in our room, the heater is not centralized so we have a problem with that.*

> "…..then there's the time that winter came and we're having a problem with the heater, since we live there like 10 persons, we having the same shift, work in the same shift like having to take a bath at the same time." - Filipino female Worker

Another participant said, *"... those who live at the houses provided by an employer mentioned that weekly cleaning service fee is deducted from their paycheques, but the cleaner actually come once a month"* (Thai male worker).

(iii) Self-Report Health Status

Participants self-reported that their physical health declined significantly since arriving in Canada. Approximately one third of participants (29%) rated their health as poor/fair, and about two thirds (66%) reported a high degree of stress since arriving in Canada. More than a third (38%) reported their mental health as poor or fair. Close to half of participants (45%) had difficulty either falling asleep or staying asleep at night, and of those, 13% experienced their sleeping issue every night, 29% at least 2-3 times a week, and 29% once a week. Although the proportion of smokers was low (18%), nearly half of participants reported drinking alcohol. Interestingly, 16% of the participants started using tobacco, and 35% initiated drinking alcohol, since their arrival in Canada.

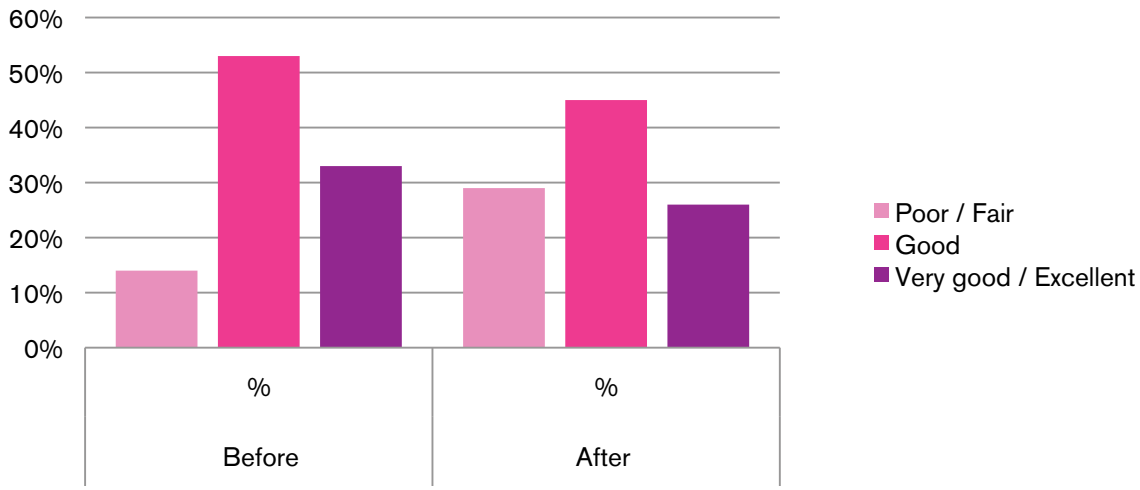

Figure 3: Overall health status

Corresponding to the above survey results, the "worries about general health problems" emerged from focus groups, especially from Thai female workers. For example, participants often mentioned the aches and pains due to long hard work:

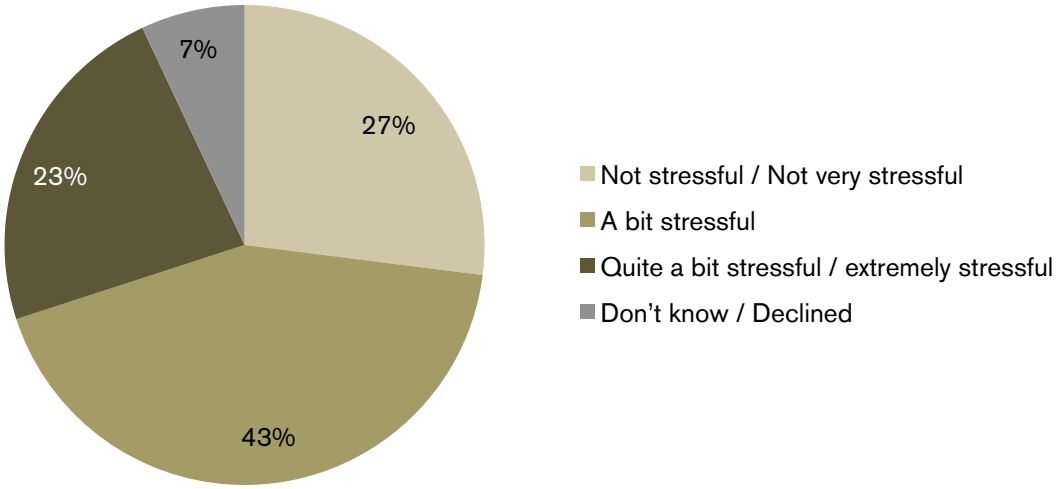

Figure 4: Amount of stress in life

> *My legs are sore after many hours of work. I pack all day and my hands are going numb when I sleep. I have two hands. So I try to switch hands. I don't want my hands to have problems. -Thai female worker*

Their stress seemed to come not only from actual physical problems, but also from worrying about their health and its consequences. As one female participant said:

> *In the past month, I haven't been well. I was tired and asked a Laotian person to take me to the doctor. He told me that I have more white blood cells than red ones. The doctor gave me supplement to take. I am worried that I might get seriously ill, like cancer or something. It's always on my mind even I am no longer tired. I don't know what is going to happen next. I'm old. I am afraid of cancer. There are several issues. I even think about going home, but I can't. It's because my family is poor.*

Another participant who had been working two jobs during the two years since her arrival in Canada also said:

> *I want to rest. But I am here to work and to make money. My family needs it. My children and niece are studying. This requires a lot of money. When there is an opportunity here, I must do it. At times I sleep only 4 hours. Often times I slept only 2-3 hours. I think of taking care of my health. If it becomes too much, I could ask the employer that I stop working. -Thai female worker*

> "I want to rest. But I am here to work and to make money. My family needs it. My children and niece are studying. This requires a lot of money. When there is an opportunity here, I must do it."
> – Thai female worker

As these statements suggest, the workers are under tremendous stress physically and mentally not only from their long strenuous work in Canada, but also from their heavy responsibility as a breadwinner for their families back home.

(iv) Sexual Health Knowledge and Sexual Practices

Overall, participants had a moderate knowledge about HIV/AIDS with a mean score of 9.8 (out of 18 scores), with scores ranging from 0–15. Questions where the participants appeared to be knowledgeable were: *"Transmission of AIDS through vaginal sex"* (88%), *"Transmission of AIDS through sharing needles"* (82%), and *"Knowing that AIDS was a big problem"* (78%). However, a considerable portion did not know that HIV can be transmitted thorough oral and anal sex (64% and 45% respectively). Similarly, 83% of participants did not know that *"Bleach can kill the AIDS virus in needles used to take drugs"*, and 77% did not know that *"Some people who have AIDS can look healthy and feel well"*. The incidence of STI and HIV testing was relatively low among participants: 11 had been tested for STIs, 4 had been tested for HIV, and 4 for both HIV and STIs.

When asked about AIDS stigma and discrimination, workers in the three focus groups expressed attitudes towards a person whom they might suspect to have HIV as generally helpful and non-judgmental. They recommended a doctor's visit, or they would take the person to see a doctor. However, this attitude is also based on workers' pragmatic and self-protective stance, i.e., they do not want to get HIV through the same group of people. Workers also reflected on structural barriers such as having difficulty in taking time off to see a doctor, the resultant income loss, and a language barrier.

From the survey, the majority (62%) of participants was sexually active in the past year, and 55% of them had sex with a regular partner. The most common methods of birth control were birth control pills (60%), followed by condoms (20%). Less than a third (22%) of participants reported having difficulty negotiating safe-sex practices with partners, but condom use was relatively low, with over three-quarters (76%) indicating that they rarely or never used condoms with regular partners.

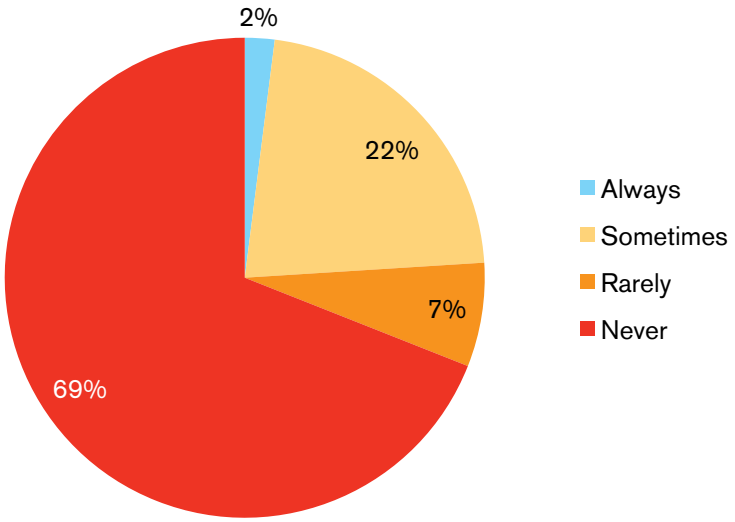

Figure 5: Use of condoms

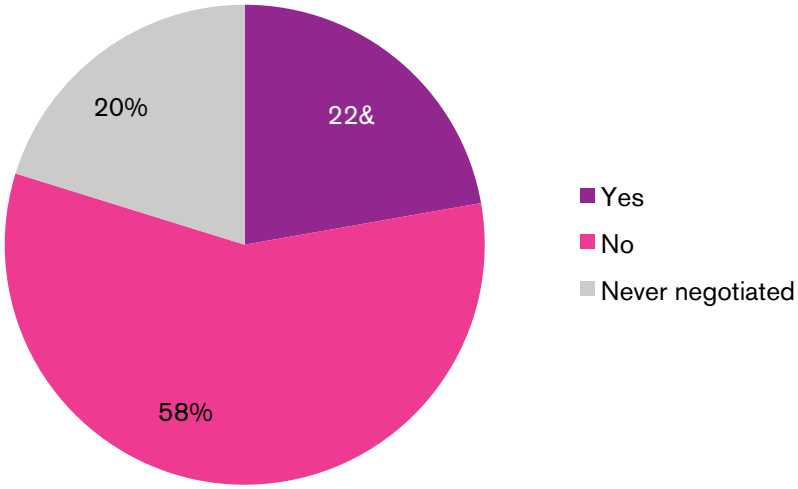

Figure 6: Difficulty in negotiating safer sex practices

In the focus groups, participants further elaborated on the reasons why they did not use condoms during sexual intercourse. Participants also discussed their fear of being infected with STIs and HIV, particularly with a casual partner. *"When we first met, most of the time we would use condoms. At the beginning, condoms are used first to prevent either [HIV/STIs] transmission or pregnancy"* (Thai female worker). However, after a few months of steady relationship, they often felt safe not using condoms with their partner:

> *Before we have sex, we must ask first, 'What if we use condoms? Is that okay with you? Can you accept this?' He said, 'Okay.' We prefer it that way. We have to protect ourselves, too. Living here, we don't know where he came from or where he had been before.... Be sure. If he is going to be with me for 2-3 months, okay, we could stop using it. It's alright. - Thai female worker*

For MFWs, condoms were inaccessible and expensive. The Thai female worker said,

> *For me, when we first met, he moved to another town. I followed him. I didn't know where to buy birth control pills and I didn't use any pills at all. Later I thought about what to do since I was afraid to get pregnant. We didn't process any [immigration] papers. Okay, so we bought condoms. We bought them, but they were expensive. He is from here so he knows a lot; he went to get them at.... So we got them, then.*

For some participants, condoms reduced pleasure and caused pain. Two female workers said, *"We used condoms but sometimes it was good, sometimes it wasn't. Sometimes we used them, sometimes we didn't."* and *"I sometimes use condoms, and sometimes I did not. It hurts sometimes."*

"We used condoms but sometimes it was good, sometimes it wasn't. Sometimes we used them, sometimes we didn't." - Thai female worker

Both Thai and Filipino workers shared how they were looking out for the safety of themselves. They hinted that having a sexual relationship with people they know or were familiar with, or workers who passed a pre-departure medical examination, is a practical way to reduce HIV/STIs risks. For example, a Thai female worker said, *"In fact, workers who came from Thailand [to work in Canada] will have to go through a health screening. He has to pass it. If he has just got here, I will trust him. However, if he has been here for some time, I'm not sure."* These factors may have played role in deemphasizing the need to use condoms and thus increased their risk for HIV and STI infection.

Although 22% of respondents in the survey reported that they had difficulty negotiating safe-sex practices with partners, some participants in the focus groups reported they had a discussion on safer sex with their sexual partners, *"I talked to him first if he ever visited prostitutes. He said when he was young, he went out with several women. I would tell him I don't like that he would have many women.I am also afraid of AIDS. It's quite widespread, isn't it?"* (Thai female worker). Thai male participants seemed to only discuss family planning issues with their sexual partners, *"... about pregnancy ... I am not ready..."* and *"Have you taken the [birth control] pills?"*

(v) Access to Sexual Health Information and Services

The majority of participants (89%) reported receiving information regarding HIV/AIDS or STIs in their home countries or in Canada. The most common sources of information were: health care providers (20%), print newspapers, magazines, educational pamphlets (18%), television (16%), Internet (10%), and other sources (10%) such as ACAS, government pre-departure orientation, seminar, and community and charity workshops.

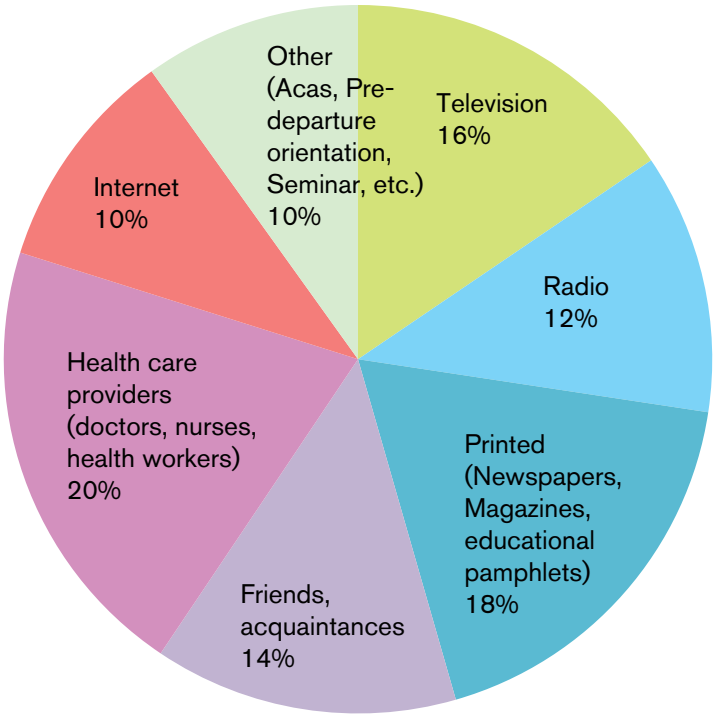

Figure 7: Source of Information

The use of sexual health services was low amongst the study participants. Only 12% reported that they had ever used these services in Canada. Those who never use sexual health services had some concerns including: language issue; not knowing where to go; not having an OHIP card or having trouble using one; medical expenses; transportation; and taking time off work to see a doctor.

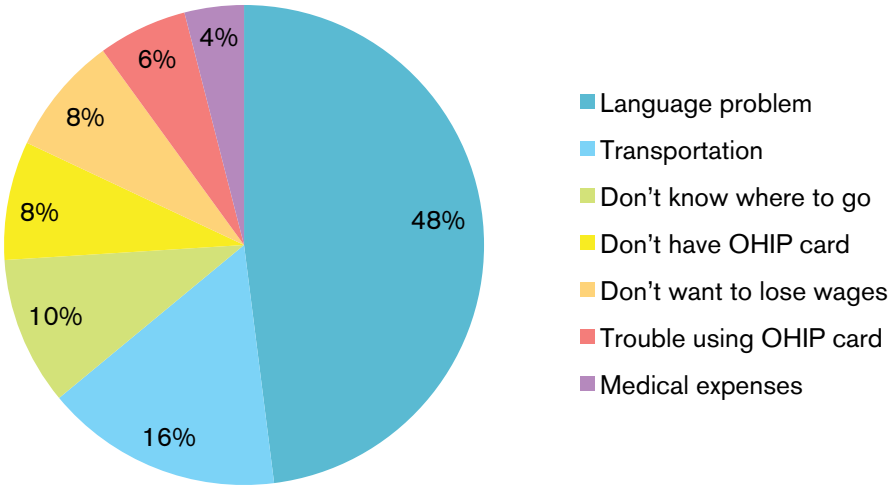

Figure 8: Concerns in accessing sexual health services

The findings of the focus groups suggested a clear difference between Thai and Filipino groups in their approach to this matter. In contrast to Filipino workers who can communicate in English with a pharmacist or a doctor in a nearby clinic and hospital, the language barrier facing the majority of Thai workers seems to limit their access to health care services in Canada, making them rely on Canadians who can speak both English and Thai such as those from the Laotian community to assist them. Some workers seek help from their family members in Thailand for information. A Thai female worker explained her situation: *"At home, I have a doctor who regularly and specifically deals with my reproductive system. ....I will call home and ask them to consult with this doctor. I am not shy about it because I really like to take care of my health."*

Regarding the difficulty in accessing sexual health services, a Thai male worker expressed his wish to have more outreach services for HIV and STI prevention in his area:

> *... Will there be an organization that would do blood test and prevent this infectious disease? I don't even know if I have it [HIV]. If there is an organization that can come to provide health services to us, that would be great... Getting tested once a year and that should be beneficial. I'm speaking of AIDS [HIV] and other diseases that we should be concerned of. We work 6 days a week, so there's not much free time.*

Other key findings of the focus groups on this matter suggested, regardless of ethnicity, participants see "sexual health as private matter". Therefore, they do not casually talk about sexual health matter with housemates, friends, and co-workers unless they encounter some problems. As a couple of Thai male workers said: *"Workers seem to be shy to talk about sex life. If people don't mention it to me first, I won't ask, so I don't hear about this stuff. They are shy."*

(vi) Social Support, Coping Strategies and Resilience

Amongst the findings which emerged from the focus groups are some assets of MFWs and their communities, such as social support networks and coping strategies developed through experience, which suggest that MFWs possess resilience.

During the first couple of months after their arrival in Canada, both Filipino and Thai MFWs received formal and/or informal social support from their ethno-linguistic communities (e.g., church groups for the Filipino workers, Laotians, and outreach workers from The Thai Society of Ontario for Thai workers). These supports include assistance with activities of daily living (e.g., donations of winter clothes, rides to shop for ethnic foods), information (e.g., briefing regarding life in Canada), and emotional support (e.g., visiting workers' apartments, going to see a doctor together), and interpreting service for the Thai group.

"We are here first, so we share money for him to buy a laptop just so to get started. So he just paid us back after he had the money."
- Filipino male worker

Although the majority of MFW participants had no family members in Canada due to the immigration restrictions imposed on them, most participants said that they frequently communicate with their family back home thanks to inexpensive global communication technologies. The Thai group seems to use smart phones more often (e.g., free communication app such as Face time, LINE), whereas the Filipino group uses laptops for Skype and Facebook. Regardless of gender and ethnicity, workers mentioned the responsibility to support their family back home:

> *I have a big family burden. My siblings are extremely poor without any means of support. We have nothing. We have no farmland. My relationship with them is to send money to help them pay for rice and food. As for my husband, since we don't have any children, so [the money is for] building our house. -Thai female worker*

Participants mentioned that they also developed a trusting "family" or "brothers and sisters"-like relationship with fellow workers, especially with their housemates. Housemates function as a core support network for both Thai and Filipino workers: "We live like 'brothers and sisters'. Whatever we have, we share. No problem. Whatever happens, we take care of each other" (Thai female worker). A Filipino male worker talked about how his housemates had collectively supported a new worker: "It's important for us to have communication with our family [back home]. We are here first, so we share money for him to buy a laptop just so to get started. So he just paid us back after he had the money."

AMFWs often spend their free time at home engaging in self-care (e.g., catching up sleep), or communicating with families back home. They also spend time with their housemates doing household errands (e.g. grocery shopping, cooking) or relaxing by watching videos or listening to music. They occasionally visit other common friends, invite them over for a house party (e.g., drinking and dancing), or go to church or cultural events together. Given the stressful and competitive conditions at the workplace, this "sense of home and family" with their housemates seems to play an important role in maintaining well-being among MFWs.

Participants developed some coping strategies for improving their conditions. Several Filipino and Thai participants mentioned that they eventually moved out from the house arranged for them by their employers, and rented a house with like-minded fellow workers to improve their living arrangements. A few Thai female workers mentioned how they had overcome the language barrier:

> *If we tried once, twice tree times, we're eventually able to go ourselves. The doctor listened to what I said and understood me. If we depend on others to take us [to see a doctor], it will be like that forever. We must be brave. We just cannot wait for others to help us.*

Since MFWs under the LSWP can stay up to four years in Canada, they seemed to learn and develop, to a certain degree, a social support network, coping strategies, and the resilience to attempt to better their living standards in Canada. However, even the better version of life is still substandard, and some resilience strategies could result in compromised health.

DISCUSSION

The results of this study show that the living and working conditions of MFWs impact their physical, mental and sexual health. A considerable number of participants reported working more than 40 hours per week and earning close to or below the Canadian low-income, after-tax cut-off point. Living in sub-standard and overcrowded housing, where they have to share not only their living but also sleeping area/bedroom with other people, could significantly promote feelings of powerlessness, loneliness, despair, restriction, lack of social control, and alienation. These conditions may make MFWs more susceptible to mental health issues such as depression.

The majority of our participants reported experiencing stress since arriving in Canada. Alcohol use and smoking, as well as difficulty sleeping, could be a manifestation of their gradual physical and mental health deterioration. The healthy immigrant effect has been reported in a few recent Canadian studies with temporary migrant workers. These studies reveal that migrant workers arrive 'healthy' as indicated during pre-departure medical screening; however their health status declines during their stay in Canada which is due to their working and living conditions, rather than a pre-existing condition (Preibisch & Hennebry, 2011; Pysklywee, McLaughlin, Tew, & Haines, 2011).

Migrant farm workers generally are involved in repetitive, manual work that often includes working on bent knees, continuous stooping, and carrying heavy loads, with few periods of relief. The employment agreements allow for only two 10-minute rest periods during the day and a 30-minute meal break after 5 consecutive hours of work. Adequate rest is important, but it may not always be attainable particularly due to MFWs' persistent fear of dismissal and deportation, as well as lack of familiarity with and knowledge of, their rights and labour regulations in Canada.

The lack of English proficiency of MFWs makes it more difficult for them to comprehend or ask for the breaks to which they are entitled. Hence it is not surprising that in our study the most common conditions that participants reported encountering were musculoskeletal problems, followed by stomach/intestinal issues, and work-related injuries. This corroborates earlier findings with migrant farm workers both in Ontario and British Columbia, which reported similar health problems even though those studies had a high concentration of MFWs from the Caribbean and Mexico (Hennebry, Preibisch & McLaughlin, 2010; McLaughlin, 2009; Otero & Preibisch, 2009).

The limited literacy and English language proficiency of MFWs, combined with a lack of familiarity with Canadian health care services, the fear of reporting concerns to employers, along with limited or no access to transportation, are among the many reasons our study participants have been hindered from seeking needed medical care. These findings are consistent with other studies conducted both in Canada and U.S. (Hennebry, Preibisch &McLaughlin, 2010; McLaughlin, 2009; Otero & Preibisch, 2009; Barnes, 2013; Horton & Stewart, 2012; Schmaizried & Falton, 2012)

Our study also showed limited knowledge of HIV/AIDS with a big difference between those who scored the highest and lowest in HIV knowledge test, low condom usage, and difficulty discussing safe sex, among our participants. Minimal knowledge, even among participants with higher education, indicates that literacy does not necessarily translate into health literacy. These factors can increase the MFW's engagement in risky sexual practices and HIV/STI vulnerabilities. The use of sexual health services was also low among the study participants. Only 12% reported that they had ever used these services in Canada.

The structural issues discussed earlier (e.g. limited English proficiency; no OHIP card; trouble using an OHIP card; transportation problems; limited social support, and long working hours) contribute greatly to their inadequate use of social and health services. Considering that most MFWs live in rural areas, work long hours, do not have easy access to transportation and lack familiarity with the Canadian health system, the use of mobile health services may be a feasible alternative to the traditional delivery of services.

RECOMMENDATIONS

In the focus groups, workers made concrete recommendations related to social and health services:

- An opportunity to exchange ideas, listen to other people's opinions, general and health problems similar to what they did at a focus group;
- An organization in Leamington, Ontario that will help workers with labour issues and ways to continue working in Canada;
- English language classes for workers.

In terms of health care services, they suggested:

- A mobile clinic to provide an annual HIV/STI test;
- An organization or someone to give health advice;
- An annual health check-up provided by employers like in other host countries;
- For female workers, a pap smear and pelvic examinations and a routine check up.

The research team determined that the removal of structural and political barriers are first steps in ensuring equitable access to social and health services for MFWs. Some strategies include:

- Enforcement of employment protection legislation for MFWs;
- Safeguarding adequate and habitable housing for MFWs through regular inspection of their housing prior to and following their occupancy;
- Provincial funding for settlement and supportive services for MFWs;
- Ensure access to accurate information about their human rights and health care coverage; and how to access health and social care;
- Ensure access to culturally and linguistically appropriate health promotion information;
- Provision of 'contextual' and culturally safe interventions to empower and address HIV/STI vulnerabilities is warranted;
- When designing sexual health information, it is imperative to take into consideration the minimal English language and health literacy levels of MFWs; materials should be translated and provided through different sources/media (e.g health care providers, Internet, pamphlets, TV).

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ACAS

Asian Community AIDS Services
Supporting Our Community, Caring For Our Future

260 Spadina Ave., #410
Toronto, ON M5T 2E4
Toll Free: **1-877-630-2227**
Tel: (416) 963-4300
Fax: (416) 963-4371
website: **acas.org**

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