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Health Responses to COVID-19 among Migrant Agricultural Workers in Ontario: Challenges and Opportunities for Change for Ontario's Public Health Units

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List of Acronyms

DRHD - Durham Region Health Department

MAW - Migrant Agricultural Worker

MWH-EWG - Migrant Worker Health Expert Working Group

OFVGA - Ontario Fruit and Vegetable Growers Association

OHCOW – Occupational Health Clinics for Ontario Workers

OMAFRA - Ontario Ministry of Agriculture, Food, and Rural Affairs

OGVG - Ontario Greenhouse Vegetable Growers

QCHC - Quest Community Health Clinic

SAWP - Seasonal Agricultural Worker Program

SES - Socioeconomic status

TFWs - Temporary foreign workers

Introduction

The COVID-19 pandemic has exposed the levels of exploitation, marginalization, and structural oppressions that migrant agricultural workers (MAWs) in Ontario have been subjected to for decades. As the federal government continues to support essential workers in all sectors of the economy throughout this pandemic, absent is accurate representation or proper acknowledgement of MAWs from the Global South, who continue to risk their lives to assure Canada's agricultural industry stays afloat. MAWs are denied equal access to social protections and face many structural barriers to accessible and adequate health care, making them extremely susceptible to COVID-19 transmission (Weiler et al., 2020). Further, the COVID-19 pandemic has increased the intensity of stressors relating to working and living conditions, social isolation, uncertainty of stay in Canada, and fear of contracting COVID-19; which exacerbates MAWs' vulnerabilities and previously existing health disparities (Landry et al., 2021).

Throughout the COVID-19 pandemic, Ontario's public health units continue to administer programs related to communicable disease prevention, overall health education, and immunizations for Canadian citizens (Ontario Ministry of Health, 2021a), however, the roles and responsibilities of public health units within MAW populations during COVID-19, have not yet been adequately investigated. Therefore, the focus of this research is to fill this knowledge gap by asking the research question of, *how have Ontario Public Health units implemented COVID-19 prevention, management, and mitigation strategies among migrant agricultural workers?* This research will examine and analyze the shortcomings, barriers, and successes of Ontario public health units' responses to COVID-19 outbreaks within MAW populations, with an aim to

investigate how factors including but not limited to lack of communication from governments, structural barriers, and precarious work environments may have contributed to the absence of specified health unit roles for this population throughout the pandemic.

The first component of this research will be a literature review that will discuss additional social determinants of health that become barriers to accessing adequate care, with a predominant focus on housing, precarious employment status, and fear of repatriation. Continually, the literature review will analyze how the COVID-19 pandemic has furthered MAWs' feeling of 'temporariness' and exacerbated inadequate health care responses from Ontario public health units.

Next, theory will be incorporated in order to further understand MAWs' social determinants of health, with areas of emphasis including socioeconomic status, income levels, race, and other psychosocial factors that contribute to health disparities and health inequities for this population. Continually, the research will incorporate a mixed methodological approach including quantitative and qualitative community-based participatory research, integrating methods including interviews and policy analysis, while concentrating on the relevant ethical, theoretical, and personal considerations that arose throughout the research process. My research design is also informed by my placement with the Migrant Worker Health Project and Migrant Worker Health Expert Working Group (MWH-EWG) as this expert working group was specifically developed in April of 2020, in order to recommend national, provincial and regional standards that ensure the health and safety of MAWs throughout the COVID-19 pandemic. Utilizing my placement will allow me to incorporate the voices of MAW advocates and migrant worker health practitioners who work within the MWH-EWG, who have been instrumental in

advocating for workers' health and wellbeing throughout the COVID-19 pandemic in Ontario, while also having direct experiences with MAWs and the barriers they face in accessing health care.

Incorporating voices of advocates, migrant worker health practitioners, and those employed in public health and health care within the scope of my research will help to illuminate structural vulnerabilities including but not limited to; whether or not MAWs had access to adequate COVID-19 safety training, how well COVID-19 control and mitigation practices were implemented and followed in MAWs' place of employment, whether or not MAWs had any familiarity with their local public health unit; as well as help to expose MAWs' experiences throughout their time in quarantine.

Next, the inclusion of a policy review will help to uncover any inconsistencies within policies that have been implemented for the primary goal of protecting MAWs from COVID-19 transmission. Federal and provincial policies from the Government of Ontario and Ontario Ministry of Health that prioritize health, safety, and levels of public health involvement for MAWs regarding COVID-19, will be compared and contrasted with each other, as well as with policies implemented by municipalities including the Regional Municipality of Durham Health Department, Windsor-Essex County Health Unit, and Niagara Public Health. The addition of a comparative analysis between these COVID-19 policies and the interview responses of MAW advocates, migrant worker health practitioners, and public health officials, will also help to illuminate primary barriers that arose when it came to the adequate implementation of these policies. This analysis will allow me to uncover systemic barriers while simultaneously creating recommendations for areas of improvement for public health units, and ensuring that the

collected data highlights the impediments faced by MAWs amid their employment in Ontario. Finally, this paper will end with recommendations for Ontario's public health units as well as best practices derived from my research findings, in order to contribute to better care for MAWs throughout their duration of stay in Ontario.

Literature Review

Overall Health Vulnerabilities

In 2018, an estimated 72% of the 69,775 temporary migrant agricultural workers who arrived in Canada did so through the Seasonal Agricultural Worker Program (SAWP), with the province of Ontario alone employing two-thirds of all SAWP participants (Caxaj et al., 2020; Hennebry, McLaughlin and Preibisch, 2016). MAWs employed through the SAWP have been coming from Mexico and Caribbean countries under temporary work visas since the 1960s, and are now most prevalent in vegetable/melon production (24%), fruit and tree nut farming (27%), and Greenhouse nursery and floriculture production (34%) (see Appendix A, F1) (Preibisch, 2004; Government of Nova Scotia, 2020). These workers are also considered "permanently temporary" as many continually come back to Canada each year, providing significant long-term benefits and crucial support to Ontario's agricultural industry; therefore, the need for their work is permanent, but they are not deemed worthy of permanent residence. MAWs' ``permanently temporary'' status is, therefore, a strategic design of the SAWP, as it not only allows Ontario growers to "obtain access to a cheap and reliable workforce" (Preibisch and Binford, 2007, p.9) thus consistently addressing these temporary labour shortages within the agricultural sector

without having to provide permanent residency to workers, but it also ensures their migrant status; as McLaughlin (2010, p.83) states "...once immigrants—or even *free* laborers—they could no longer be compelled to work in agriculture, let alone be bound to a single employer" (see also Haley et al., 2020; Caxaj et al., 2020).

Access to this workforce through the SAWP also perpetuates the racialization of this labour market, as it allows the agricultural industry to implement employment practices that would not be acceptable to Ontario workers. Under the SAWP, employers are given the right to select workers "...on the basis of nationality and gender, rather than work experience, skill-set or training" (Hennebry and Preibisch, 2012, p.25), which simultaneously contradicts Canada's Employment Equity Act that states "no person shall be denied employment opportunities or benefits for reasons unrelated to ability" (Employment Equity Act, 1995, p.1). Preibisch and Binford (2007) surveyed employers within Canada's agricultural industry, in order to further expose the reasoning behind their racialized allocation of labour. One grower rationalized:

> Jamaicans like more physical work. In their society work is...digging or lugging pots for men, weeding for women, while Mexicans don't discriminate between these types of work...Give them a hoe and they will outwork the Jamaicans every time. (p.18)

With another Canadian grower stating:

> We have the Mexican women who just strictly stay in the packing barn. I tried using Jamaicans in the vineyard and you know, you can call it stereotyping, but they don't hold a candle to the Vietnamese...they're just like machines, they're really good...Jamaicans are better peach pickers…(Preibisch and Binford, 2007, p.18).

This racialization and gender-stereotyping of MAWs then becomes a 'best practice' for employers, as it not only promotes competition between workers, leading to an increase of production, but it also facilitates demand from labour supply countries wanting to increase and

uphold their job placements in Ontario via “good workers who meet employer’s expectations”; therefore perpetuating the exploitation of a labour force consistently seen as disposable and easily replaceable (Hennebry and Preibisch, 2012; McLaughlin, 2010).

McLaughlin (2010) further defines the SAWP as a “managed migration scheme” that continues to define an ‘ideal worker’ as those who are compliant, “work hard, obey the rules and are completely flexible; they do not aspire to advance their position, develop personal or romantic relationships, or settle in Canada'' (McLaughlin, 2010, p.80). In pursuance of this ‘ideal’ criteria, MAWs applying into the SAWP have the ability to manipulate their profiles in order to conform with employers’ as well as sending governments’ hiring preferences. This often undermines workers’ abilities on paper and re-enforces an employment scheme that dehumanizes and belittles workers’ intelligence and skillsets, as the SAWP favours those with low education rates and few job prospects (McLaughlin, 2010).

MAWs’ precarious status within the SAWP is also an inherent driver of their vulnerability as this program entitles MAWs to only one rest day for every six consecutive workdays, with an average working day consisting of eight hours of work (McLaughlin, Hennebry, and Haines 2014). Even though the agricultural sector is included in the Employment Standards Act, MAWs are excluded from numerous key elements of this act including hours of work, minimum wage, daily/bi-weekly rest periods, overtime, and holiday pay (McLaughlin, Hennebry, and Haines 2014). The SAWP also grants employers the opportunity to request that workers postpone any rest days, leaving this population to work an average of 63-65 hours per week, with these hours having the ability to increase depending on the season and demanding harvest periods (Binford, 2002; McLaughlin, Hennebry, and Haines 2014). Therefore, MAWs’ willingness to forsake

weekends, holidays, and evenings, as well as their motivation to work efficiently under conditions most Canadians will not accept, described by Moyce and Schenker (2018, p. 352) as "dirty, dangerous, demanding, and degrading", continues to justify their vitality to agricultural employers who have had to increase their reliance on this workforce. Further, as the Canadian agricultural industry continues to uphold the highest rates of musculoskeletal injuries, toxic chemical injuries, occupational injuries, and fatalities than other workforces, with these risks and hazards heightened for MAWs due to their precarious status via long work hours, MAWs' access to proper health care and protection policies is crucial (Moyce and Schenker, 2018; McLaughlin, Hennebry and Haines, 2014).

MAWs are required to pay into Canadian employment insurance premiums, income taxes, and generally receive legal access to provincial health care, however, under the SAWP, workers have extremely limited access to these social protections despite their contributions (Pysklywec et al., 2011; Hennebry et al., 2016; McLaughlin and Tew, 2018). A survey of nearly 600 MAWs in Ontario, conducted by Hennebry, McLaughlin, and Preibisch (2010), revealed that 92% of workers did not know how to fill out a hospital form, and 85% did not know how to make a health insurance claim. Further, the same study in 2016 concluded that 93% of workers surveyed were unaware of how to access workplace safety insurance, and only 22% stated that they had received information on Ontario's health care and insurance systems (Hennebry, McLaughlin and Preibisch, 2016).

The barriers MAWs face when trying to access the health services they pay into include but are not limited to: extremely long working hours and lack of transportation (making government buildings inaccessible), lack of knowledge about eligibility, and linguistic and

cultural competency barriers within the health care system (Cole et al., 2019). Inaccessible health care therefore not only threatens MAWs' livelihoods but also further exacerbates their "permanently temporary" status, as they are forced to navigate a system designed for Canadian citizens (Hennebry et al., 2016; Mclaughlin, Tew and Huesca, 2018).

The SAWP also magnifies the "permanently temporary" rhetoric that MAWs are subjected to as it utilizes closed work permits, which do not permit workers to freely change employers, thus allowing employers to have inordinate control over this population, including their ability to fire workers without recourse to an appeals process, normally triggering their repatriation. MAWs' status of employment sitting precariously in the hands of the employer creates an extreme power imbalance, as this fear of repatriation is a constant for many workers, making them less inclined to communicate their needs, injuries, illnesses, or voice any concerns about their work environment for fear of being sent home or not rehired the following season (Cole et al., 2019; Vinita, 2020; Weiler et al., 2020; Haley et al., 2020). These fears are also not without merit, as Orkin et al., (2014) disclosed, 787 medical repatriations among Ontario MAWs from 2001-2011, with 41.3% of workers repatriated for medical/surgical reasons with diagnostics including but not limited to musculoskeletal injuries, cancer, and respiratory and cardiovascular health concerns, and 25.5% for external injuries relating to extremities, spine, head, thorax, face or from poisoning.

Consequently, these levels of exclusion, racialization, and precariousness embedded into the SAWP ensure that workers feel expendable and therefore largely remain compliant (Basok et al., 2014; Caxaj et al., 2020). These intersecting structural vulnerabilities that impact MAWs'

access to health care and negatively affect their overall livelihood have now been further exacerbated by the COVID-19 pandemic.

Overall Health Vulnerabilities furthered by COVID-19

In December of 2019, the World Health Organization (WHO) reported the first outbreak of SARS-CoV-2, and in March of 2020, the WHO declared the diseases a pandemic with 100,000 cases reported worldwide, and countries around the world being forced to go into lockdown (Purkayastha et al., 2021). With the government's declaration of essential businesses as "necessary to keep society functioning" (Purkayastha et al., 2021, p.5) throughout the pandemic, included in those deemed essential consisted of health care workers, first responders, and food and agricultural workers who continue to provide for society while simultaneously working in hazardous and high-risk environments (Public Safety Canada, 2021). Further, varying conditions of work, employment, and socioeconomic conditions as well as potential gaps in health and safety measures within these essential sectors, all play a role in influencing the spread of COVID-19.

When it comes to the risk of infection, the Government of Canada (2021a, para.1) states,

> ...COVID-19 spreads from an infected person to others through respiratory droplets and aerosols when an infected person coughs, sneezes, sings, shouts, or talks...the virus may also spread when a person touches a surface or an object that has the virus on it...

In order to prevent the spread of COVID-19, advised public health measures in Ontario consist of avoiding enclosed spaces with poor ventilation, wearing a non-medical or medical mask

when in a shared space outdoors and indoors, maintaining physical distancing of two meters, and avoiding any settings in which these risks overlap (Government of Canada 2021b) These recommendations are particularly challenging to implement for MAWs, who cannot work from home, whose living and working conditions limit their ability to social distance, and who are reliant on employers to provide proper ventilation, PPE, and sanitary stations (Purkayastha et al., 2021; Government of Canada, 2021b; Caxaj et al., 2020; Haley et al., 2020; Hennebry et al., 2016).

Under the federal standards for housing, those who employ MAWs must provide one sink and one toilet per seven workers, as well as one shower per ten workers (Haley et al.,2020; Dale, Fehr, and Pfenning, 2020). MAWs are normally housed in shared dormitory-style rooms, with six to eight workers allowed within the "minimum cubic volume of space required per worker" (Haley et al., 2020; Dale et al., 2020). These overcrowded bunkhouses are also known to have poor ventilation and lack appropriate privacy and handwashing stations (Cole et al., 2019; Haley et al.,2020; Preibisch and Hennebry, 2011). The enforcement of these unsafe housing measures increases the risk of communicable disease transmission within this population; as thoroughly demonstrated by the COVID-19 pandemic, with MAWs in Ontario estimated to be contracting COVID-19 at a rate ten times higher than the rest of the population, with three workers in Ontario dying after contracting COVID-19 in 2020 and additional deaths in 2021 (Preibisch and Hennebry, 2011; Dale et al., 2020; Kelley, Wirsig and Smart, 2020; Migrant Workers Alliance for Change, 2020).

The limited COVID-19 guidelines that *have* been put in place specifically for this population, however, in some cases have been not only ineffective but also discriminatory and

xenophobic. In 2020, MAWs in the Norfolk and Halton regions were subjected to “prison-like'' quarantine measures, as workers were prohibited from leaving their bunkhouse or farm property, with doing so being considered grounds for removal from Canada (Hennebry, Caxaj, McLaughlin and Mayell, 2020). In March of 2021, the Haldimand-Norfolk health unit further denied fresh air brakes for MAWs throughout their 14-day quarantine period and left this population to administer COVID-19 swabs tests on their own with minimal instructions. Further, the Norfolk public health unit also distributed ID cards to MAWs to be used as proof that they had completed their quarantine process, which has since been retracted “after being criticized for racially profiling workers'' (Hennebry, et al., 2020, para.18).

Continually, as Weiler et al., (2020) point out, the federal government and the SAWP have placed too much responsibility on the employers when it comes to the health and safety of MAWs, which has had drastic, negative consequences throughout the COVID-19 pandemic. As of April 22, 2021, employer criteria include but are not limited to: a requirement to obtain separate accommodations for workers not subject to quarantine measures; provide COVID-19 information and best practices for MAWs in their specified language; immediately provide new isolation accommodations if a worker tests positive at any given time; and provide private transportation for MAWs upon arrival to Canada, after obtaining a COVID-19 test (Government of Canada, 2021c; Government of Canada, 2021d). As previously stated, employer-worker relationships are fragile under the SAWP, therefore, employers are not adequately equipped to handle these quarantine responsibilities, “as they are often not well-positioned to fulfil this role” (Caxaj et al., 2020, p.19).

As of March 30th, 2021, the addition of vaccine roll-outs, led by local public health units,

has now been added to the complex and continually shifting COVID-19 protocols for this population. Although all residents of Ontario now have access to COVID vaccinations, in most Ontario regions MAWs were prioritized early for receiving the vaccine when their supplies were limited. For example, the Niagara region prioritized vaccinations for MAWs based on risk factors including:

1. Risk of exposure to infection with the ongoing flow of new arrivals
2. Risk of severe illness or death due to the increased prevalence of chronic conditions within the migrant worker population
3. Risk to disrupt critical supply chains and local economy (Public Health and Emergency services, 2021)

The vaccination of MAWs is stated to be a “multi-pronged approach across different levels of government” with provincial and federal governments currently prioritizing strategies for the vaccination of MAWs upon immediate arrival to Canada (Public Health and Emergency services, 2021). Implementing adequate and fully consensual distribution of the vaccine to this population poses additional challenges that correspond to confusion and hesitancy for MAWs when it comes time to obtain their vaccine. These challenges can include but are not limited to, vaccine misinformation, lack of consideration to whether the vaccines given are available to MAWs in their country of origin, and inadequate time to discuss health concerns with a professional. Moreover, as the MWH-EWG (2021, para. 4) discusses, “The power imbalance between employers and migrant workers in Ontario agriculture presents unique challenges to obtaining informed consent [to the COVID-19 vaccine]”.

Additionally, the pandemic has increased MAWs' susceptibility to contracting COVID-19 and correlating workplace injuries/illnesses as it has exacerbated previously existing health disparities, and increased workers' already extensive and exhaustive working conditions (Landry et al, 2021). As employers continue to be put under immense pressure in order to ensure the pandemic causes minimal to no disruption to Ontario's food system, Landry (2021) points out, that this then correlates to reports of MAWs working 15 hour days, seven days a week, to make up for workers who were unable to travel. Continually, the fact that Canadian citizens are not being subjected to the same quarantine measures or COVID-19 protocols and working environments as MAWs further exacerbates worker vulnerabilities; as Hennebry et al., (2020, para. 17) state, it "sends a signal that migrant workers are a risk rather than *at* risk".

Theoretical Approach

The use of critical theory allows for structural elements that result in health disparities and inequities to be highlighted. Critical theory places emphasis on social concerns between intergroup struggles as they are determined by characteristics including race, ethnicity, and gender (Paradis et al., 2020), and further emphasizes "power-rich contexts, dominant discourses, and social justice issues" (Leavy, 2017, p.13). Therefore, critical theory will be used as an overarching guide to the theory of health justice, utilizing an intersectional justice approach in order to illuminate health inequities and injustices within the public health sector. Further encompassing the intersections of social determinants of health, seen as "the conditions in which people are born, grow, live, work, and age...shaped by the distribution of money, power and resources at global, national, and local levels" (Borras, 2020, p.207), is also vital to understanding migrant health outcomes as various structural socioeconomic inequalities

that underlie health disparities. Therefore, including an intersectional approach to health inequity during the COVID-19 pandemic will reveal that preexisting class and race/ethnicity-based health injustices are “shaped, interconnectedly, by economic maldistribution, cultural misrecognition, and political misrepresentation” (Borras, 2020). The theory of health inequity then becomes an important component in determining and understanding underlying, structural causes of health disparities that further affect those in historically marginalized groups.

To start, “health disparity” can be defined as,

> ...a particular type of health difference that is closely linked with economic, social, or environmental disadvantage...adversely affecting groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group... socioeconomic status...geographic location; or other characteristics historically linked to discrimination or exclusion (Health People, 2021, para.5).

In contrast, health inequities can then be understood as “the structural or institutional patterns that ultimately result in health disparities”, including the maldistribution of social determinants of health (Braveman, 2014; Heath, 2020). Therefore, advocating for health equity correlates to reducing these disparities via “striving for the highest possible standard of health for all” (Braveman, 2014, para.7); while simultaneously prioritizing the needs of those at greatest risk of poor health due to underlying social conditions. Understanding the theoretical factors of health inequities that intersect with social determinants of health, including socioeconomic status, psychosocial circumstances, and employment and working conditions is vital in identifying what factors put people “at risk of risks” (Link and Phelan, 1995).

Socioeconomic status (SES) is a primary driver of health inequities, as it influences an

individual's life conditions (i.e. differences in income, power, and wealth), which then generates a higher or lower prevalence of health issues (WHO, 2010). In a society in which the exclusion of MAWs is structural and ongoing, examining their socioeconomic status can reveal inequities in access to health resources, as well as highlight other issues related to power. Additionally, not only are those with low SES more likely to have worse self-reported health, suffer from higher rates of chronic conditions, and are subject to a lower life expectancy than those of higher SES, but those of lower SES also receive fewer diagnoses and medications for a variety of chronic diseases, face barriers to adequate health care due to cost and coverage, and possess fewer resources to lessen the negative impacts of an adverse health event (Arpey, Gaglioti, and Rosenbaum, 2017; Leonard, 2017)

MAWs are also often living in poverty, as the income they receive while working in Ontario is, on average, just above minimum wage (McLaughlin, 2010). Wells et al., (2014) analyze the vitality of remittances for families employed within the SAWP, with total SAWP remittances to Mexico increasing from CAD 152.7 million in 2010 to CAD 174.1 million in 2012; with the average remittance per worker in Mexico totalling CAD 9,879.322 in 2012. These remittances, however, do little to address or improve the structural poverty found within MAWs' countries of origin, as the remittances are primarily used for expenses that consist of but are not limited to, buying homes and new appliances, educating children, and paying off debt or medical expenses (Wells et al, 2014). Consequently, the SAWP is arguably not the primary contributor to low SES for MAWs, however, as Wells et al., (2014, p.146) state, "...scholars debate how much remittances are contributing to more diversified, sustainable economic development relative to simply reinforcing ongoing dependency at low-income

levels''. Therefore, as MAWs continue to face a cycle of precarity driven by the structural systems they work within, and ongoing poverty stemming from their country of origin, any unforeseen negative health event can then disrupt employment, incur more health care costs, and increase their vulnerabilities within the SAWP, which all pose a great risk to their immediate health.

Psychosocial factors that impact health include discrimination, feelings of social exclusion, low social support, and stressful living circumstances and can further increase one's stress response, thus leading to elevated heart rates and high blood pressure (Arcava et al., 2015; WHO, 2010). Different social groups experience psychosocial factors in varying degrees, however, social groups that have systematically experienced higher levels of racial/ethnic discrimination are more likely to have demoralizing and emotionally negative experiences to health care, thus exacerbating health inequities (Arcava et al., 2015).

Discrimination in general, and racism in particular, is an important social determinant of health that intersects with SES. Previous research has shown MAWs face many forms of discriminatory behaviour from employers, governments, and the general public. Racial discrimination can impact one's wellbeing via increased psychosocial stress, pose as a barrier to accessing health and other social resources, and can increase experiences of violence and bodily harm (Davis, 2020). Discrimination due to race, gender, or sexual orientation continually influences access to health care and can also trigger other challenging or traumatic experiences in life, including but not limited to, unemployment or being exposed to poor-quality environments and housing (Davis, 2020). Therefore, "discrimination acts as both a stressor and

a cause of other stressors, and can, directly and indirectly, lead to harm for those who experience it" (Davis, 2020).

For MAWs, psychosocial factors that adversely affect health, including feelings of social exclusion due to language barriers and discrimination, have drastically increased during the COVID-19 pandemic. A study conducted by Dhanani and Franz, (2021, p.2) concluded that public health epidemics, like an infectious disease outbreak, "may heighten the expression of prejudice toward specific groups and immigrants''; as has been demonstrated throughout the xenophobic public health measures and public responses to migrant workers that have been occurring within Ontario, as previously mentioned. MAWs' reliance on their employers for accessible social support and services via the internet, cell phones, and other resources also further impact psychosocial factors of health, as access to these forms of social support come with barriers and are often limited or nonexistent.

MAWs' employment and working conditions are also factors that impact social determinants of health, as they are susceptible to numerous health concerns via exposure to risks including, but not limited to, agrochemicals, animal-borne diseases, lack of adequate PPE, climatic extremes, machines, and repetitive ergonomic positions (McLaughlin, 2010; McLaughlin, 2009; McLaughlin, Hennebry and Haines, 2014; Landry et al., 2021). Although the SAWP contract specifically outlines the requirement for adequate health and safety training and protective clothing for MAWs, these "occupational health and safety protections are inconsistent and often insufficient" (McLaughlin, 2010b, p.31). In the same survey as previously

mentioned, conducted by Hennebry, McLaughlin, and Preibisch (2016, p.532), 52% out of 600 MAWs surveyed stated that, in general, “working in the SAWP was hazardous to their health”.

It is important to highlight how the social determinants of health issues MAWs face are compound and intersect, as these factors correlate to health inequities and health disparities for MAW populations. As the COVID-19 pandemic continues to disproportionately affect those from ethnic communities that have been historically minoritized, decades of institutional and structural racism have contributed to increasing health disparities for these populations, which needs to be accounted for when determining and implementing better COVID-19 strategies for Ontario's Public Health units. Pursuing health justice for this population will therefore require strategies and interventions from public health units that integrate cultural recognition, accurate representation, and redistribution of resources throughout the COVID-19 pandemic.

Research Structure

Methodology and Methods

The research consists of a mixed methodological approach, incorporating quantitative and qualitative community-based participatory research. Qualitative research approaches consider the value of individuals' subjective experiences, which helps the researcher to build a strong foundation and understanding of their research topic (Leavy, 2017). As the goal of my research is to identify the roles and responsibilities of public health units within MAW populations during COVID-19, qualitative approaches to my research are vital as they allow inductive research questions that “seek to illuminate, explore, and understand” (Leavy, 2017). Qualitative approaches help unpack meaning and further my understanding of both MAWs’

experiences during COVID-19, as well as the experiences of advocates, migrant worker health practitioners, and those employed in public health who have been working with this population. Further, integrating theory will also help to identify major themes throughout the process of data collection, in order to compare and contrast my research findings with pre-existing literature. The inclusion of a community-based participatory approach will further enhance my research goals, as it employs values also found in qualitative approaches, including collaboration, trust, knowledge sharing, and the prioritization of invoking structural change (Leavy, 2017).

Community-based participatory research approaches facilitate relationships between non-academic stakeholders and researchers, in order to develop research projects that encompass a specific community-identified issue (Leavy, 2017). The addition of this approach will help me prioritize diverse voices within the community of my research, including migrant worker health practitioners, advocates, and public health workers. Through this approach, the inclusion and participation of all stakeholders mentioned will be equally valued, as all voices are needed when it comes to identifying core issues and collectively coming up with solutions and recommendations based on my research findings. To accompany these methodologies, my research methods will include interviews with advocates, migrant worker health practitioners, and public health workers, as well as a policy analysis, as utilizing these methods will help to further identify barriers to health care that MAWs experienced amid their employment in Ontario; and will help my research to grasp public health units' level of involvement when it comes to the health and safety of this population, as well as create comprehensive recommendations and opportunities for change for Ontario's Public Health units.

The addition of a policy analysis within these research methods will help to address, examine, and analyze the implementation of Ontario's public health units section 22 class order issued under the Health Protection and Promotion Act, under which a "medical officer of health can issue an order to require a person to take or refrain from taking any action in respect of a communicable disease" (Public Health Wellington-Dufferin-Guelph, 2020). Systematically investigating these policies specifically implemented to manage the spread of COVID-19 within this population will therefore allow for an in-depth comparison to data collected from interview participants, in order to expose any gaps and/or barriers to the physical execution of these policies; while also helping my research to grasp local public health units' level of involvement when it comes to the health and safety of this population.

Interview participants consisted of advocates, migrant worker health practitioners, and those employed in public health, who have worked closely with MAWs throughout the COVID-19 pandemic. The addition of their collective expertise with this population is vital to include when it comes to identifying challenges/barriers that public health units may face in adequately implementing policy for this precarious population; as well as in producing recommendations and opportunities for change in order to provide MAWs with better access to health care.

My interview participants were determined through purposeful sampling, as this sampling strategy relies on the researcher's decision to acquire data from individuals based on the premise that they will be the best source for information needed (Mertens, 2009). Interview participants included advocates, migrant worker health practitioners, and those employed in the public health sector; these stakeholders were some of the best to engage with throughout

this research process, as they had first-hand experience with this population throughout the pandemic. Interviewing a variety of participants also reflects the reality of the types of positions and stakeholders involved that are relevant to ensuring the health and safety of this population. In order to acquire information specifically catered to my research question, interview questions that were asked, ascertain general themes relating to communicable disease transmission, vaccination strategies, whether or not public health policies were accurately followed/enabled, monitoring and assessing isolation/quarantine procedures, and identifying primary barriers faced by public health that could limit their capacity to help MAW populations throughout COVID-19.

The information was gathered and recorded via the interviewer's personal phone recorder and transcribed immediately after using Otter.ai as well as by hand. Otter.ai helps to record conversations, allowing them to be reviewed and played back for accurate transcriptions. The recorded and transcribed information will be accessible to the researcher and supervisor, with all electronic information stored on the password-protected personal computer of the researcher. The process of value coding was implemented, as this coding strategy places emphasis on identifying conflicts, struggles, and power issues (Leavy, 2017). Utilizing this coding process allowed for themes to be pulled from the data gathered to obtain clear links between my research questions and the concepts that are being compared within my research, in order to produce valid findings. Continually, there are also ethical considerations that arise through this form of data collection.

Ethical Considerations

For the ethical considerations of interview participants, I distributed letters to obtain

informed consent after the proposal was approved by the REB. The letter of informed consent outlined the purpose of this study as well as identifiable risks, potential benefits, how confidentiality will be insured, and how the data will be mobilized, as well as a document to sign identifying their consent to participate in the research. I maintained confidentiality for interview participants wherever possible, in order to mitigate any risks of potential harm associated with their participation after the research has been mobilized. I also emphasized the fact that the health care barriers faced by MAWs are structural problems and are therefore not problems induced by individuals employed within the public health sector.

As Leavy (2017, p.32) discusses; "*do no harm,* is the primary principle governing the protection of research participants''. In researching the roles and responsibilities of Ontario public health units for MAWs during the COVID-19 pandemic, my goal is to follow this rhetoric and contribute to better strategies for public health units in order to improve the accessibility of health care for a population inherently suppressed, yet vital to Canada's food system and agricultural industry.

Results and Discussion

COVID-19 policy analysis

There has been a multitude of policies put into place specifically for MAWs at federal, provincial, and municipal levels. As of March 31st, 2020 the policies implemented by the Ontario Ministry of Health (2020), also highlighting local public health involvement include but are not limited to:

1. All Temporary foreign workers (TFW) will be exempt from air travel restrictions as well as border restrictions
2. TFWs who enter Canada by air or land will undergo the necessary health checks and must isolate for 14 days upon arrival to Canada
3. TFWs will remain isolated from the general population while travelling to farms and to their housing, therefore transportation must be arranged by farm and food businesses
4. If a TFW is not able to properly isolate from other housemates, the local public health unit should be contacted to provide consultative advice on isolation and accommodation...alternative housing should be discussed with the local public health unit
5. The local public health unit and Medical Officer of Health are responsible for the public health management of COVID-19, including the investigation and coordination of an outbreak response, and providing guidance and recommendations to workplaces.
6. Each farm/food business should notify the local public health unit of new TFW arrivals and discuss further guidance/inspection of housing as needed
7. If COVID-19 is suspected in a TFW...return to work should be determined in consultation with the employer...and local public health unit (Ontario Ministry of Health, 2020a; Ontario Ministry of Health, 2020b).

There have also been significant changes/updates to these guidelines in response to COVID-19 on-farm outbreaks in 2021, with the Ontario Ministry of Agriculture, Food, and Rural Affairs (OMAFRA) releasing "*Prevention, Control, and Outbreak Support Strategy for COVID-19 in Ontario's Farm Workers",* and the Government of Ontario releasing "*COVID-19: Farmer Toolkit",* both of which outline action items, with many of these items to be administered/implemented by employers, Public Health Ontario, Ontario, and local public health units. These include but are not limited to:

1. Government to provide active training for farmers on how to conduct screening, and relay messages about appropriate PPE and procedures to follow in the case of a positive COVID-19 case
2. Planning in consultation with local public health units should occur for outbreak responses to determine how those who test positive for COVID-19 will be managed
3. Documentation of any movement of workers, specifically when involving interactions with other people, will help to facilitate contact tracing for public health if needed

4. Government and industry to ensure the public health guidance given to all Ontarians on social interactions with regard to COVID-19 prevention recommendations is translated and provided to all workers
5. Workers are required to conduct and submit a self-administered COVID test on day 8 of arrival
6. Local public health units will be responsible for investigating and declaring an outbreak of COVID-19, and once an outbreak is declared local public health will also be responsible for managing those impacted (OMAFRA, 2021; Government of Canada, 2021e).

Continually, there have also been policies put into place at municipal levels that aim to further implement federal and provincial mitigation strategies. For the Regional Municipality of Durham Health Department as of February 6th, 2021, for example, those policies include but are not limited to:

1. Ensuring arrangements are made for sufficient provision of food, water, masks, linens, a means of communication (internet, phone, television)...Meals must be nutritious...Employers must accommodate cultural and dietary restrictions.
2. No TFW can be moved into a non-inspected living accommodation without notification and approval from Durham Region Health Department (DRHD).
3. Ensure that DHRD is contacted for approval if renovations occur within pre-existing and approved living accommodations that impact floor space, number of faucets, toilets, showers, and/or bathtubs.
4. Notify DRHD if any TFW needs to leave the farm/isolation location for any reason during the 14 day isolation period, such as to seek medical attention.
5. Ensure that all individuals present to DRHD for case and contact management as required and that any individuals under DRHD supervision for case and contact management have ongoing access to communication devices (cellular phone or landline) and this contact information is made available to DRHD. (Regional Municipality of Durham, 2021) (See appendix A, F2, for the full list of policies)

Windsor-Essex brings another municipal example, further implementing a class order document containing COVID-19 requirements issued to all operators and owners of agricultural farms in the county, updated April 1st, 2020, with their action items including but not limited to:

1. Requirement to conduct daily health checks of all individuals under quarantine or self-isolation
    a. Document all health checks and provide them to the health unit within 24 hours if requested.
2. Provide COVID-19 information and educational material to all new arrivals in their native language
    a. Post information about preventing the spread of COVID-19 in all entryways, common areas, bathrooms, and kitchens
3. Ensure workers under quarantine or self-isolation are able to notify the employer if they become symptomatic
    a. Provide training on how to contact employer in the event of symptom onset
4. Notify the Windsor-Essex County health unit if the workers need to leave their accommodation for any reason, during their quarantine period, such as to seek medical attention
5. A complete and accurate list including first/last name, date of birth, address, and phone number of all workers (TFW, local, temporary or contract) is to be made available to the Windsor-Essex County Health Unit upon request within 24 hours (Windsor-Essex County Health Unit, 2021) (See appendix A, F3 for full list class order).

A third municipal class order implemented on July 10, 2020, that was compared to interview participants comes from the Niagara region, in which they also disclosed notable reasoning behind the implementation of this order, after "...At least 3 temporary foreign workers have died as a consequence of COVID-19 in Canada," and

> "...Temporary foreign workers experience multiple social barriers, including language and cultural barriers, that lessen their access to health care and prevention, increasing the risk that COVID-19 infections may not be diagnosed in a timely manner, and outbreaks may occur" (Niagara Region Public Health, 2020).

Even with the acknowledgment of MAWs social barriers to health care, and the deaths that COVID-19 has caused within this population, Niagara region class order action items include:

1. If a worker fails their daily screen, ensure the employee is able to isolate from other workers in a separate room or building; as well, provide assistance to the worker to be tested for COVID-19 if the worker consents to be tested.
2. Supply medical-grade face masks to all workers so that they can protect themselves and each other when 2-meter physical distance is not possible.
3. Ensure that all workers are informed of and understand their rights and entitlements, including access to health care services and other supports that may be available if that worker becomes sick.
4. Facilitate Quest Community Health Centre or another provider endorsed by Niagara Region Public Health in any request to offer health assessments or health care to workers.
5. Ensure that any worker who must isolate due to symptoms of COVID-19, being tested for COVID-19, or being a contact of COVID-19 receives full pay or a reasonable approximation thereof for the time they must isolate, either through the Workplace Safety Insurance Board or through any other arrangement of the choice of the employer. (Niagara Region Public Health, 2020). (See appendix A, F4 for full policy)

Although these examples of policies and acts identified at all levels of government have been put into place for employers, government, and public health units to help mitigate control, and protect MAWs from COVID-19 transmission, the increase in MAW deaths relating to COVID-19 as of 2021 is a clear indicator that these mitigation strategies are not being effectively and adequately implemented by all stakeholders. First, there are inconsistencies within these policies, when it comes to who is responsible for the physical and mental health and wellbeing of MAWs throughout their quarantine, which generates confusion and incohesive care for MAWs upon their arrival to Ontario. Provincial, federal, and municipal policy overlap concerning MAWs' quarantine process consists of employers being accountable for ensuring MAWs have access to healthy, fresh, culturally appropriate food "without inflated prices or surcharges" (Government of Canada, 2021f) throughout their time in quarantine; and it is also the employers' responsibility to "provide the worker with wages during the initial quarantine period

for a minimum of 30 hours a week...at the hourly rate of pay…"(Government of Canada, 2021f). Windsor-Essex's policy outlines the implementation of an action item specifying a "...requirement to conduct daily health checks of all individuals under quarantine or self-isolation...." (Windsor-Essex County Health Unit, 2021, p.2) and the Niagara region outlines the need to "Facilitate Quest Community Health Centre or another provider endorsed by Niagara Region Public Health in any request to offer health assessments or health care to workers", (Niagara Region Public Health, 2020, p.2). However, there is no mention of mandatory daily health checks for workers in quarantine within OMAFRA's *Prevention, Control, and Outbreak Support Strategy for COVID-19 in Ontario's Farm Workers* or within the Government of Ontario's *COVID-19: Farmer Toolkit,* with the exception of the Government of Canada's *Guidance for employers of temporary foreign workers regarding COVID-19,* stating that "the government asks employers to monitor the health of workers who are in quarantine" (Government of Canada, 2021c). Without an adequate description of what exactly "monitoring" should consist of for employers and no consistent implementation of mandatory daily health checks from local public health units, there is a lack of accountability of all stakeholders which has already had drastic, negative consequences. This can be seen with the deaths of several workers in 2021, including Fausto Ramirez Plazas who died May 20th, 2021 after contracting COVID-19 in government-mandated quarantine; Romario Morgan, who died 13 days into his two-week quarantine and was found unresponsive in his hotel; Logan Grant, who died March 13th, 2021 while in quarantine for eight days; Jose Antonio Coronado who died April 23rd, 2021 in quarantine for seven days (cause unrelated to COVID-19); and Roberto Jacob Baca Gomez

who died March 22nd, 2021 in quarantine for three days (Migrant Worker Alliance for Change, 2021; Mojtehedzadeh and Keung, 2021).

Another policy that can be critiqued, that was created to help mitigate the risk of COVID-19 consists of "...Ensure[ing] workers under quarantine or self-isolation are able to notify the employer if they become symptomatic…[and] provide training on how to contact employer in the event of symptom onset" (Windsor-Essex County Health Unit, 2021, p.2). Yet again, this policy does not take into account the power dynamics and precarious relationships between employers and MAWs. Mandating policies that require MAWs to report symptoms to employers, or to increase employer interactions in any capacity, becomes a broader issue as research previously mentioned has shown that the SAWP's allowance and implementation of employers to have inordinate control over this population, including premature repatriations, creates a barrier for MAWs to feel comfortable with telling their employers if they feel sick (Cole et al., 2019; Vinita, 2020; Weiler et al., 2020; Haley et al., 2020); or in the case of the COVID-19 pandemic, have become symptomatic throughout their quarantine process/duration of stay in Ontario in fear of losing their jobs and the ability to send repatriations home to their family.

In contrast, some aspects of these policies proved successful when it came to increasing MAWs' access to health care. One policy implemented by the Regional Municipality of Durham consisted of ensuring "...arrangements are made for...a means of communication [including] internet, phone, [and] television...for TFW" (Regional Municipality of Durham, 2021). Ensuring workers have access to communication devices can allow for MAWs to educate themselves on concepts related to vaccine information, find resources in their area, and better understand how to either take themselves in for COVID-19 testing or how to effectively administer self

COVID-19 tests. This action item, however, was not collectively enacted in all regions, therefore, ensuring workers have access to communication devices can be seen as a best practice for other public health units in Ontario to employ within their section 22 class orders. Continually, responses of interview participants also identified critiques, highlighted areas of improvement, and exposed barriers to adequate implementation of these policies.

Comparative analysis between COVID-19 policies and interview participants

Semistructured interviews were conducted as this qualitative research practice allows for questions that do not need to have a predetermined response, and for participants to have the opportunity to use their own language and provide their own detailed responses (Leavy, 2017). Five interviews were organized, with all interview participants providing full consent to having their names included within my research. The interview participants included in this research consisted of the following five individuals:

1. Stephanie Mayell, a member of the MWH-EWG, and Ph.D. candidate in the medical anthropology program at the University of Toronto, who has been conducting community-based health research and support with MAWs in both Ontario and Jamaica since 2014.
2. Michelle Tew, also a member of the MWH-EWG and an occupational health nurse with Occupational Health Clinics for Ontario Workers (OHCOW), who has been working with migrant farmworkers since 2006.

3. Nancy Garner, Executive Director of Quest Community Health Centre (QCHC), an organization that has been providing primary care to the seasonal agricultural workers in Niagara for 11 years.
4. Sendi Struna, manager of the Healthy Environments program for the past five years within the Regional Municipality of Durham, in which migrant farm accommodations are inspected.
5. Azunai Ivany Cano Flores, an advocate for MAWs in Southeast and Southwestern Ontario who has been working with this population for many years. [1]

Conducting these interviews allowed me to compare and contrast policies implemented by Ontario's public health units, with those in the health sector and others who work closely with, and have advocated for MAWs throughout the COVID-19 pandemic. Within these interviews, there were many overlapping similarities and overall key findings that helped to illuminate public health units involvement in the health and safety of MAWs throughout COVID-19, while simultaneously contributing to an understanding of the barriers faced by public health officials when it came to implementing COVID-19 prevention and mitigation strategies. The first key finding consists of the fact that prior to COVID-19, Ontario's Public Health units' primary level of involvement for this population was in ensuring employers were providing adequate housing for their workers. As Sendi Struna, manager of Durham Region's Healthy Environments program states,

> ...Prior to COVID, our [experience with migrant workers] was extremely limited...it was more just getting the inspection program going, making sure that the accommodations were inspected...we didn't really have any direct contact with any of the workers,

[1] Did not consent to including title or organization within report.

> because all of the inspections would be completed prior to the arrival of the workers (Struna, 2021).

COVID-19 has illuminated a knowledge gap between the public health sector and the vulnerable population that is Ontario's MAWs. There is a clear need for the public health sector, which has taken on the responsibility of creating and implementing resources catered to this population, to have a general overview of the systems under which MAWs are employed. However, "...public health is tasked with keeping us all safe...not just the most vulnerable, but *including* the most vulnerable" (Mayell, 2021); in essence, COVID-19 has stretched public health to its maximum, often resulting in the lack of capacity, resources, and infrastructure needed to ensure public health has a thorough understanding of the barriers MAWs face in accessing adequate health care *before* they implement resources and recommendations specifically catered to this population. At the same time, COVID-19 has also posed a unique opportunity for public health to be more involved, and partner with, community organizations that help protect and advocate for MAWs.

For Durham Region Public Health, partnering and reaching out to organizations including the Black Physicians of Ontario, as well as the Durham Region Migrant Worker Network, helped with promoting and supplying MAWs with culturally appropriate resources. As Struna (2021) states, "learning about the Durham Region Migrant Worker Network has been so eye-opening for us and honestly...I really credit...that relationship with helping us to understand...some of the nuances of what's going on". Continually, Nancy Garner, Executive Director of Quest Community Health Clinic (QCHC) in the Niagara region, also identified Niagara Public Health as

being exemplary in reaching out to, and getting involved with other social services that support MAWs like themselves, in order to provide appropriate care to MAWs:

> ...[Prior to COVID-19, public health] was definitely...not in the mix...we worked really closely with our community providers but public health was not in that mix, and this really brought the two together and it just makes so much more sense" (Garner, 2021).

Further, QCHC also identified a process map to demonstrate exactly how public health was involved with and worked alongside, different stakeholders throughout both proactive farm visits and reactive outbreak responses (Garner, 2021). These maps identified public health as being more involved in a reactive COVID-19 outreach response, with duties including conducting case and contact tracing to see who was exposed to COVID-19, implementing prevention and control measures, alerting Emergency Medical Services of a potential outbreak, and analyzing COVID-19 lab test results (see Appendix F5 for full proactive map, and F6 for full reactive map).

Another key finding that these interviews helped to illuminate consists of the fact that employers seem to be bearing the burden of operating in ways they are not qualified for, with public health imposing a heavy reliance on employers when it comes to the implementation of COVID-19 health and safety measures. As we can see in the policies analyzed, there is a multitude of action items implemented by various public health units that require the employer to be well-versed in communicable disease transmission and how to protect against it, which becomes extremely impractical for the employer. As Michelle Tew, an occupational health nurse for migrant workers states,

> ...The responsibility to do a lot of COVID... protections or implementation of rules...was passed down to employers….[public health] were...expecting the employers to be... infection control professionals…and [have] the ability to...design both workplaces,

> working conditions, as well as housing conditions to prevent the spread of infection (Tew, 2021).

As the policies analyzed demonstrated, employers were also expected to educate MAWs around COVID-19 transmission, provide daily check-ins as well as a multitude of resources, and report any symptomatic cases, therefore putting employers in positions of health care providers or assessors; something they are seldom equipped to be. As Mayell (2021) sheds light on,

> ...It's important to recognize that employers are not health professionals, and they're actually persons running a business...It's, it's a different perspective. It's not focused on caring for the human needs that are emerging out of the individual workers that you have employed, and to be generous, of course, employers and farmers have very many other things that they have to worry about, because of COVID.

Continually, public health delegating an influx of tasks to employers further demonstrates again, the fact that the public health sector is not fully educated on the precarious status of MAWs, their potentially unstable relationships with their employers, or whether or not their employers have the capacity and resources needed to provide them with the necessary arrangements to protect against COVID-19. As Struna (2021) states,

> The one thing as a local public health unit I don't understand very well is how [access to health care for MAWs] works..and what...the employers' responsibility on that is...it would be helpful for the health units to understand that.

Ontario's public health units not having the capacity to fully understand worker-employer relationships also contributed to an unintended consequence of some action items within these policies, with this consequence being more control of worker populations granted to employers. The responsibility given to employers of mitigating COVID-19 transmission becomes a conflict of interest, as the literature review previously noted since employers are within their right to not call a worker back the following season if they speculate that the worker may not be of adequate health for that season. MAW advocates interviewed, including Azunai Ivony Cano

Flores and Stephanie Mayell, both shared examples of employers denying freedom of movement off-farm to workers, not providing workers with accurate information on the relationship between vaccination and their employment, or in one instance, of workers bringing their concerns of symptoms of themselves and their bunkmates to employers, with the employers then stating they 'had the flu and should take a Tylenol' (Mayell, 2021; Azunai Ivony Cano Flores, 2021). For most employers, it is clear that their priority is their business, which they are adequately equipped to handle and run. Therefore, allowing them to have more control over MAWs in the form of COVID-19 protection protocols, something they are *not* adequately equipped for, can lead to unintended consequences, as can be seen in prior examples within the literature review.

Further, my research also discovered that not having cohesive action items for all public health units within the section 22 class order led to many missed opportunities to provide adequate care to MAWs. For example, Niagara Region's section 22 class order identified the need to ensure that all farms had to allow Quest Community Health Centre to contribute to, and provide health assessments and health care to MAWs (Garner, 2021; Niagara Region Public Health, 2020). This action item was extremely important as it allowed for an organization that fully understood the difference in needs for this population, and was also not associated with public health or the employers, to provide culturally appropriate and adequate health care to workers when necessary. Even though Durham Region did partner with other community organizations, thus allowing them to gain a better understanding of this population's needs, it was not a mandatory requirement within their section 22 class order. This brings me to my first,

if not most important recommendation for Ontario's Public Health units: having a worker-centred approach.

Recommendations and Best Practices

Based on the research findings, the first recommendation for Ontario's Public Health units would be to partner with community services and implement mandatory informational resource packages that are region-specific for MAWs. Durham region, for example, put together a welcome pamphlet for MAWs that listed local health services, local and culturally specific grocery stores, contact names and numbers of local support personnel, as well as who to call if a worker has a complaint about their safety or housing (See appendix A, F7 for full pamphlet). Not only are information packages important for workers to get a sense of their surroundings, but as Mayell (2021) discussed within her interview, they can have the potential to play a vital role in protecting MAWs health throughout their duration of employment:

> I saw a lot of workers this year being sent to farms for the first time and brand-new communities in the middle of a pandemic. And I think that's un-ideal...when there is the potential for an increased need for health care, workers are completely in the dark about where they are...

So as to achieve a more worker-centred approach, these resource packages should also be created in collaboration with MAWs themselves pre-season, in order for Ontario's public health units to obtain a better understanding of what workers would like to know, and the information that would be the most helpful for them to have upon arrival to the farm in which they will be employed. Incorporating workers' voices into these information packages will also help to illuminate gaps in workers' knowledge and understanding of processes, such as how to access

health care, employment insurance, or other services they may need, but lack the knowledge to acquire.

Continually, one overlapping theme that was referenced by all interview participants, was the need for mental health resources catered specifically to this population to be included within these packages. The importance of mental health resources to be accessible to MAWs is vital, especially throughout their quarantine; as Azuani (2021) mentioned, “They [workers] were having a really hard time with quarantine. Very boring. Very lonely and really long... a lot of them were...really, really having a difficult time struggling with quarantine”. Azuani also displayed an exemplary tool and resource that she distributes titled “Iniciativa, Te Escucho” (I Hear You Initiative), a mental health resource in Spanish with the goal of creating listening spaces, and providing MAWs access to health professions and consultants while remaining confidential (see appendix A, F8 for resource poster). Public health officials utilizing a worker-centred approach, and collaborating with available community services and MAW support organizations, will allow them to create resource packages that are culturally appropriate, available in different languages, and regionally-specific, therefore lessening the pressure on employers to provide this information, consequently increasing the level of trust that MAWs can have in what they are receiving.

The COVID-19 pandemic has clearly demonstrated the need for my second recommendation, being for Ontario's Public Health units to implement an intersectional and worker-centred approach when creating and distributing resources and protection strategies for MAWs in Ontario. As Stephanie Mayell (2021) discussed, “...it’s the difference between seeing a problem and trying to address it, or seeing a problem and taking a worker-centred approach to

a solution that's human". Taking a worker-centred approach could look like collaborating with organizations like the Migrant Worker Health Project, Quest Community Health Centre, Occupational Health Clinics of Ontario or other groups that are regionally specific but unassociated with government and employers, that know and understand the needs of MAWs as well as the barriers they face to accessing adequate health care. These partnerships could also contribute to bridging the knowledge gap between public health and Ontario's migrant agricultural workers, as Sendi Struna (2021) identified the positive relationship had, between Durham public health and the Durham Region Migrant Worker Network: "We don't really want to lose the momentum...for us here...we have really developed a strong and open relationship with the network". Not only does communicating with other stakeholder groups allow for the potential of more cohesive and culturally appropriate care to be provided to MAWs by public health, but it can also foster an opportunity for increased resource distribution, as demonstrated by Durham region. Implementing a worker-centred approach would also look like employing one clear stakeholder group that has unmediated access to MAWs, ensuring they have a direct point of contact as soon as they arrive in Canada. As Stephanie Mayell (2021) stated within her interview,

> What I really noted was the absence of a stakeholder or group of stakeholders who were involved in making sure that workers had accompaniment through the process of arriving and transitioning...if we had someone or some group of persons...I don't think we would have lost so many workers this year.

A single point of contact for MAWs could help to alleviate the stressful circumstances they are often put in and would help to bridge the communication gap that we have consistently seen between governments, employers, and public health units when it comes to

who is responsible for the protection and health of MAWs in Ontario. Tew (2021) also noted the importance of this stakeholder group as it would allow for the workers' needs to come first, rather than the employers, as "...it also goes back to answering the questions that the workers have, not necessarily answering the questions that we have, that we think that they need" (Tew, 2021). A stakeholder group with a worker-centred approach will also include the voices of MAWs and would be "...independent of employers, independent of their consulates, or independent of anyone that could control their ability to continue to work or to be in this country" (Tew, 2021). It could ensure much-needed, trusting relationships between all stakeholders involved in supporting MAWs throughout their duration of stay in Ontario.

Continually, one group that would be well suited for this role consists of the MWH-EWG, as they have consistently been on the forefront of advocating for MAWs in Canada, specifically throughout the COVID-19 pandemic. This group utilizes two decades of research in order to provide cohesive recommendations to Canadian, Caribbean, and Mexican governing bodies, with their primary goal to "facilitate collaborative identification of strategies to increase these workers' access to healthcare services and workers compensation" (MWHP, 2021). The MWH-EWG utilizes input from medical experts, clinicians, academics, and other social service leaders in order to develop recommendations s that ensure both living and working conditions for MAWs allow for action items within the section 22 class orders mentioned, including but not limited to, the ability to social distance, self isolate, and communicate symptoms, are effectively and adequately implemented to prevent the spread of COVID-19. The MWH-EWG has also published recommendations including but not limited to: recommendations for accommodation requirements for MAWs, Canada-Mexico SAWP recommendations, as well as their own

recommendations catered to Ontario's public health units in order to increase health service access to MAWs; therefore, as the MWHP-EWG is neither government nor employer associated, it can be assured that the recommendations published are non-biased and fully implement a worker-centred approach to protecting this population. One shortcoming of this stakeholder group, however, is the fact that they do not have the power to ensure that these recommendations are adequately implemented, or turn into government-mandated policy.

This brings me to my third recommendation, that independent stakeholder groups like OHCOW, the MWP-EWG or QCHC be consulted by Ontario's public health units, in order to ensure that policies and other recommendations are being adequately implemented on farms that employ MAWs. The Canadian government should also initiate these interactions in a timely manner to ensure recommendations can be acted upon quickly in an ever-evolving context. Along with Ontario's public health units, commodity groups that are beneficiaries of migrant agricultural labor, including but not limited to the Ontario Fruit and Vegetable Growers Association (OFVGA) as well as Ontario Greenhouse Vegetable Growers (OGVG), need to be held accountable in ensuring the health and safety of a population that is central l to Ontario's food system and agricultural economy. Adding an independent stakeholder group that can monitor, assess, and track these action items will help to ensure that they are being implemented appropriately and sufficiently in order to protect MAWs throughout their duration of stay in Ontario. The consulting of this independent group should be made mandatory for all entities that employ MAWs, with funding being provided in the form of government grants; in which both commodity groups and Ontario's public health units can apply in order to support any and all expenses that this will incur.

Lastly, as my research has demonstrated, there is a correlation between the health and safety of MAWs, and the farm in which they are contractually obligated to work for. In order to really ensure that the health and safety of this population is at the forefront, centralized and continuously upheld, structural changes to the SAWP need to occur; specifically referencing the need to remove the policy in which workers are contractually obligated to be tied to a single employer while in Ontario. Allowing workers to have the right to choose their employer, like the vast majority of Canadians already do, would increase their autonomy thus increasing their mental and physical wellness as well as their feelings of safety and security; all of which, as demonstrated within the theory section of my research, will increase their overall level of health. Providing MAWs with the ability to choose their farm, and whether or not they will come back to the same farm the following season, would also diminish the level of control and 'ownership' that is granted to employers via the SAWP.

Dismantling the level of control that has been placed with employers also has the ability to diminish MAWs' levels of stress and fear when it comes to employer repatriation. Without this control and level of power, there is the potential for employers to be more likely to treat their workers in a just and humane way and uphold the recommendations and policies given to them in order to ensure MAWs come back to work on their farm the following season. The allowance for MAWs to have more authority over their living and working conditions could also positively influence their socioeconomic status and simultaneously alleviate some psychosocial factors that impact health including stressful living and working conditions. MAWs should be treated with a level of respect that equates to their level of vitality for our food system, in which we would have no food system without them; and their need to have equal rights within

Ontario's workforce is justifiable as they continue to work in an industry refused by most Canadians due to its strenuous and often dangerous working conditions. Therefore, allowing MAWs the freedom of choice along with the ability to leave an employer without fear of repatriation is one small step closer to providing them with the just and equitable workplace they deserve.

Conclusion

Data collected has shown that low socioeconomic status and coinciding health inequities and disparities, a lack of health and safety education, fear of repatriation, inadequate housing, and the power imbalance imposed by the SAWP, all foster an environment for communicable disease transmission within migrant agricultural worker populations in Ontario. COVID-19 has impacted Ontario's migrant agricultural workers immensely, causing fear, confusion, mental and physical distress, and even death in some circumstances: with MAWs contracting COVID-19 at a rate ten times higher than the general population (Kelley, Wirsig and Smart, 2020). Overall, it has been the job of Ontario's Public Health units to implement health and safety measures to protect populations from COVID-19 transmission, however, as my research has demonstrated, there are some barriers, gaps, and inconsistencies in the roles and responsibilities of Ontario's public health units when it comes to COVID-19 mitigation, protection, and management strategies for this specific population.

As my research has shown, Ontario's public health involvement for this precarious population prior to COVID-19, only had roots in the implementation of housing standards for employers. The limited background knowledge on MAW populations that Ontario's public

health units had when it came to workers' vulnerable relationship to employers, obstacles to health care they face, as well as their social determinants of health, was an extensive barrier to creating policies that fully catered, *appropriately,* to the needs of MAWs throughout the COVID-19 pandemic. One specific action item discussed by Windsor Essex Public Health, which was also included in other public health class orders throughout Ontario consisted of the specificity that all "...workers under quarantine or self-isolation are able to notify the employer if they become symptomatic…[and] provide training on how to contact employer in the event of symptom onset" (Windsor-Essex County Health Unit, 2021, p.2). This policy illuminates a broader issue in the fact that it does not take into account the power imbalance between MAWs and their employers, particularly, employers having the ability to repatriate MAWs on the grounds that they fall sick or become injured under the SAWP (Orkin et al., 2014). Therefore, it becomes a conflict of interest for workers to report signs of illnesses or COVID-19 symptoms to employers as they do not want to lose their job, nor do they want to be forced into quarantine as this diminishes the paid hours they are able to work. Further, the policy review conducted also illuminated a lack of responsibility from all three stakeholders including government, employers, and Ontario public health officials, when it came to checking in on MAWs' health and well-being throughout their quarantine process. This proved to be a large gap in providing MAWs with accessible and adequate care throughout their official time in quarantine and consequently resulted in the deaths of multiple workers.

Including the voices and opinions of interview participants ranging from advocates, migrant worker health practitioners, and those employed in Ontario's public health sector further allowed me to compare and contrast my research findings and policy review with

outlooks of those who have been working alongside MAWs throughout the COVID-19 pandemic. Within these interviews, questions were asked pertaining to communicable disease transmission, assessing/monitoring quarantine processes, and vaccination strategies/involvement, in order to identify whether or not public health policies were accurately followed/enabled.

There were also limitations that arose throughout the research process, the first being that I was unable to include more interview participants within the public health sector, due to the research project's tight timeline. Although several public health officials were invited, only one agreed to participate. The ability to include more health units would have been beneficial, as it would have allowed for a more in-depth analysis of Ontario's public health responses to MAWs throughout the pandemic. However, even with a limited number of participants across different stakeholder groups, I believe data saturation occurred, as the themes were becoming redundant and consistent across participants. Nonetheless, further research comparing public health units' various experiences and perspectives is warranted.

Further, these interviews helped to identify areas of improvement for Ontario's public health units when it comes to increasing MAWs' access to health care and aided me in the creation of multiple recommendations including:

1. For Ontario's public health units to partner with community services and implement mandatory informational resource packages that are region-specific for MAWs upon arrival.

2. For Ontario's Public Health units to implement an intersectional and worker-centred approach when creating and distributing resources and implementing protection strategies for MAWs in Ontario.
3. For independent stakeholder groups like the MWH-EWG, OHCOW, or local CHCs to be consulted by commodity groups that are benefitting from migrant agricultural labour, as well as to be consulted by Ontario's public health units, in order to ensure that policies and other recommendations are being adequately implemented on farms that employ MAWs, with these interactions to be mandated by the government and funded via government grants.
4. For structural changes to the SAWP to occur, specifically removing the policy in which workers are contractually obligated to be tied to a single employer throughout their duration of stay in Ontario, as this has the potential to increase livelihoods and decrease employer control over this population.

It is important to note that my major research project (MRP) utilizes a public health framework, and has been focused on addressing the immediate concern of limiting COVID spread and providing COVID-related care; thus my recommendations can be understood largely as s mitigation strategies that have *immediate* implications. However, as my literature review mentioned, MAWs face many structural barriers to obtaining health care and protecting their health. Macro-level recommendations, including permanent residency and open work permits, are fundamentally important when it comes to the long-term protection of this population. Groups including the MWH-EWG, Justicia for Migrant Workers, Agricultural Workers Alliance,

and the Migrant Workers Alliance for Change, continue to promote and create recommendations needed to address the structural factors that underpin health inequities for this group and promote long term change. Many of these can be found in detailed reports, such as *Unheeded Warnings, COVID-19 and Migrant Workers in Canada (MWAC 2020)* and, *2020 Canada-Mexico SAWP Negotiations: Recommendations From the MWH-EWG (MWH-EWG 2020).* While I recognize their importance, such topics were beyond the scope of my MRP.

Overall, in answering the research question of, *how have Ontario Public Health units implemented COVID-19 prevention, management, and mitigation strategies among migrant agricultural workers,* it can be stated that Ontario's public health units involved in this research lacked the education and understanding of this population, which limited their capacity to employ the appropriate prevention, management, and mitigation strategies needed in order to fully protect workers from COVID-19; as demonstrated by the numerous cases and deaths of MAWs through the 2020-2021 seasons. As MAWs are a precarious population distinct from Canadian citizens, their needs and requirements of protection are vastly different, and it is vital for Ontario's public health units to acknowledge and understand this moving forward in order to ensure MAWs have better access to health care and prevention strategies.

Finally, the knowledge obtained from this research demonstrates the fact that there is an abundance of stakeholder groups that want to improve access to health care for migrant agricultural workers. They are a population as deserving of accessible and adequate health care as every Canadian citizen, and the global pandemic has clearly demonstrated their vitality to our country as a whole. Various stakeholder groups mentioned within this research including employers, Ontario's public health units, and the Canadian government need to prioritize the

health and safety of this population via recognizing the recommendations distributed by the MWH-EWG, and ensuring they are adequately implemented *before* there is another preventable outbreak or COVID-19 related death within this population.

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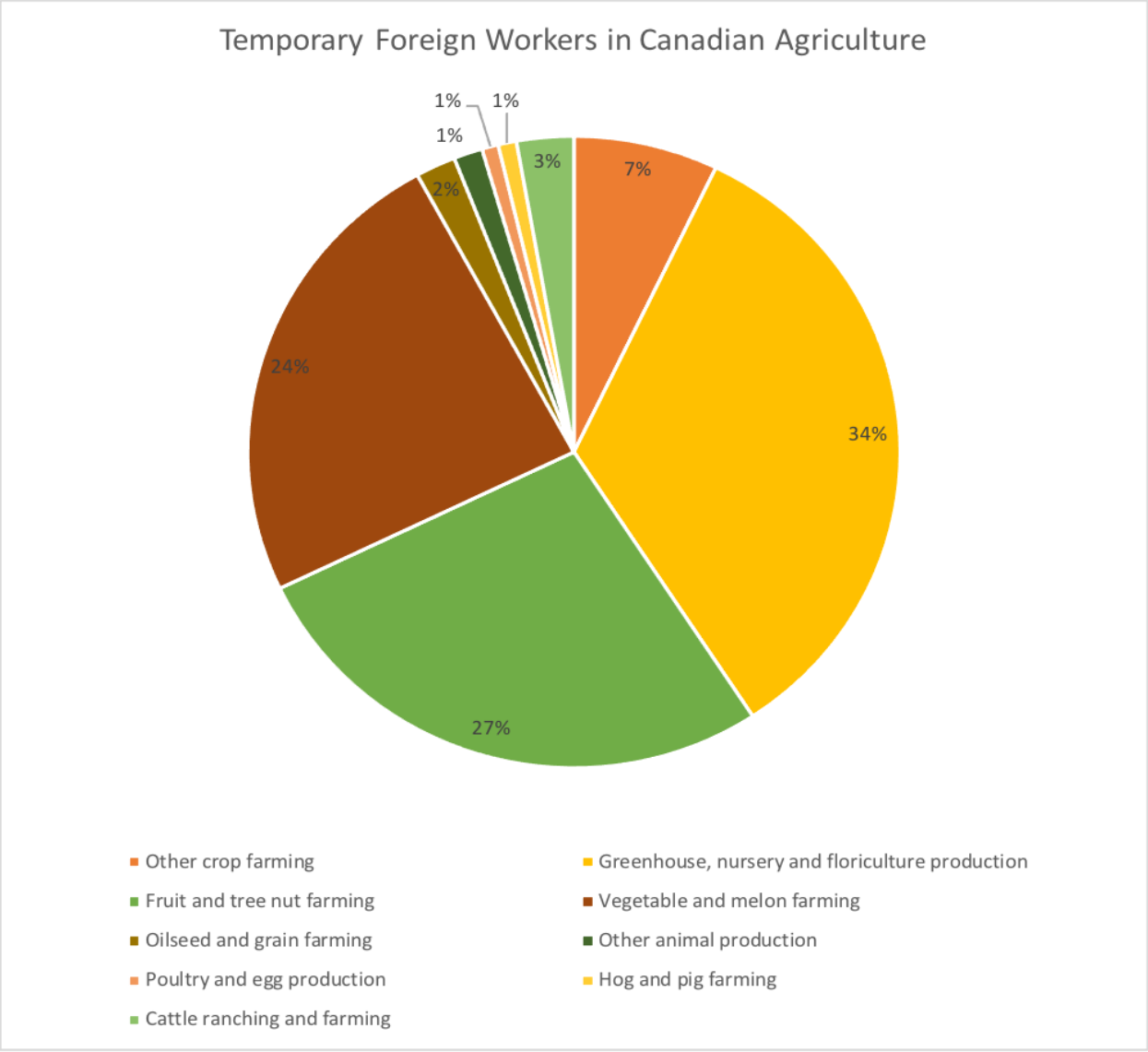
Appendix A

F1: Number of workers, share of 54,734 jobs held by temporary foreign workers in 2018. Graph created from information retrieved from the Government of Nova Scotia. (2020). Temporary Foreign Workers in Agriculture, 2016-2018.



F2: COVID-19 Policies Durham Region

Retrieved from Regional Municipality of Durham. (2021).

DURHAM REGION

The Regional Municipality of Durham

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CLASS ORDER

made pursuant to Section 22 (5.0.1) of the Health Protection and Promotion Act

Date: June 24, 2020 **Revised Date:** February 6, 2021

TO: All owners and operators of agricultural farms in the Regional Municipality of Durham who:

a) Employ migrant farm workers in any capacity and/or participate in the federal Temporary Foreign Workers program (collectively the "TFWs"); or
b) Operate any model of seasonal housing accommodations

I, Dr. Robert Kyle, Medical Officer of Health for the Regional Municipality of Durham, pursuant to section 22(5.01) of the *Health Protection and Promotion Act* ("HPPA"), ORDER you to take the following actions, **effective 12:01 am on February 6, 2021:**

1. Ensure that all employees current or future are exclusively working within one workplace. Employees who are employed at more than one agricultural farm operation must immediately limit this to one agricultural farm.

2. Ensure that any contracted employees current or future are exclusively working for one agricultural farm operation. Individuals who have been contracted by more than one farm operation at a time must immediately limit this to one premises.

3. Ensure that all TFWs who have arrived in Canada are isolated for 14 days from the date of arrival in Canada, as per the *Quarantine Act*.

4. Keep a list of names of all TFWs scheduled to arrive in Canada, their planned date of arrival and a plan for isolation of the TFWs.

5. Ensure TFWs in isolation are kept at a minimum of 2 metres apart from other employees or provide a separate room or alternative accommodation for the TFWs in isolation.

6. Ensure that no TFW works on any farm until after the completion of their 14-day isolation period.

7. Ensure that arrangements are made for sufficient provision of food, water, masks, linens, a means of communication (internet, phone, television) and personal hygiene products (e.g. soap, shampoo, sanitizers with 60-90% alcohol concentration etc.) for TFWs

completing isolation requirements. Meals must be nutritious and well balanced. Employers must accommodate cultural and dietary restrictions for TFWs under isolation. TFWs under isolation must also be able to store food in a safe manner.

8. Ensure that TFWs in isolation have access to adequate laundry and cleaning supplies.

9. No TFW can be moved into a non-inspected living accommodation without notification and approval from Durham Region Health Department (DRHD).

10. Ensure that DRHD is contacted for approval if renovations occur within pre-existing and approved living accommodations that impact floor space, number of faucets, toilets, showers, and/or bathtubs.

11. Notify DRHD if any TFW needs to leave the farm/isolation location for ANY reason during the 14-day isolation period, such as to seek medical attention.

12. Ensure that all known instances of non-compliance with the *Reopening Ontario (A Flexible Response to COVID-19) Act 2020*, the *Quarantine Act, or the Health Protection and Promotion Act* are reported immediately to the appropriate agency.

13. Conduct daily (as a minimum) active screening for symptoms and exposure history of COVID-19 for all employees and visitors using the provincial screening tool available for workers and employees at https://covid-19.ontario.ca/screening/worker/ (or equivalent) prior to or upon entry to the workplace premises. Keep records of screening for at least one month and ensure those records are available to DRHD, as requested.

14. Ensure that all employees that work on farms are assigned to the same team/group/work pod (the "cohort") and are separated from other individuals and teams.

15. Within the cohort, employees should maintain a two metres physical distance from other workers. The need for PPE should be based on a risk assessment that may take into consideration factors such as local epidemiology and input from the DRHD.

16. For greater clarity, employers are to group TFWs in the workplace based on their housing arrangements/residence. TFWs are to work with only the colleagues with whom they reside, to the greatest extent possible.

17. Ensure that all TFWs understand their rights and entitlements, including access to healthcare services and other supports that may be available if a worker becomes sick and is required to isolate. Provide COVID-19 information and educational material to all new TFWs in their native language.

18. Provide continuous cleaning and disinfecting supplies to all TFWs for the purpose of cleaning and disinfecting their living space.

19. Ensure that there is an alternative accommodation available for isolation.

20. Ensure that accurate and updated contact information for all employees (permanent, temporary, or contract) is available to be provided to DRHD within 24 hours of request, in support of case management and contact tracing requirements.

21. Develop and implement a written safety plan available on-site for viewing by employees and visitors. This safety plan must be posted in a conspicuous location. All TFWs must follow the safety plan. The safety plan must include provisions addressing the following:

    a) Active screening of all employees and visitors
    b) Self-isolation for employees if they become ill while at work
    c) Physical distancing and a procedure to address crowding inside and outside the workplace premises and ensure all employees maintain a distance of 2 metres apart
    d) Face coverings for employees and visitors, with limited exemptions
    e) Cleaning and disinfecting of the workplace premises
    f) Support of hand hygiene for employees and visitors, particularly handwashing and/or use of hand sanitizer, as applicable
    g) Reminding employees and visitors about good respiratory (cough and sneeze) etiquette and to avoid touching their face
    h) Notification to DRHD of any employee either diagnosed with COVID-19 or identified as a high-risk contact to someone with COVID-19;

22. Follow any directions provided to you by DRHD pertaining to COVID-19 and the terms of this Order. This may include ensuring adherence to self-isolation orders issued to any employees, ensuring that required public health measures such as active screening and physical distancing are maintained at all times within your workplace, and supporting all aspects of investigations related

to communicable diseases, including COVID-19, conducted by the DRHD.

23. Ensure that all individuals present to DRHD for case and contact management as required and that any individuals under DRHD supervision for case and contact management have ongoing access to communication devices (cellular phone or landline) and this contact information is made available to DRHD.

24. Ensure cooperation and compliance with DRHD with regards to prevention of COVID-19 outbreaks on your premises and ensure prompt communication and compliance with all DRHD imposed outbreak measures, as required.

25. Comply with any further instructions form DRHD pertaining to this Order as it relates to an investigation and/or an outbreak at the premises.

THE REASONS for this ORDER are that:

1. COVID-19 has been designated as communicable under Ontario Regulation 135/18 as amended. COVID-19 has been declared a pandemic by the World Health Organization.

2. COVID-19 is present in the Region and therefore poses a risk to the health of the residents of the Region through community transmission. The COVID-19 virus (SARS CoV-2) is spread from an infected person to a close contact by direct contact or when respiratory secretions from the infected person enter the eyes, nose or mouth of another person.

3. The risk of transmission of COVID-19 is greatest in close contact environments where persons are within 2 m and/or without face coverings. Persons may be infected with COVID-19 without showing symptoms, and may spread COVID-19 to other persons, their families, and others with whom they come into contact.

4. Cases of COVID-19 and percent positivity of tests for COVID-19 continue to increase in the Region.

5. Agricultural farms that employ TFWs have been the site of many large outbreaks of COVID-19 in Ontario as well as elsewhere in Canada.

6. TFWs experience multiple social barriers, including language and cultural barriers, that lessen their access to health care and prevention, increasing the risk that COVID-19 infections may not be

diagnosed in a timely manner, and outbreaks may occur.

7. The need for a precautionary approach to public health interventions is a recognized principle that applies to Orders issued under the HPPA.

I am of the opinion, on reasonable and probable grounds that:

a) a communicable disease exists or may exist or there is an immediate risk of an outbreak of a communicable disease in the health unit served by me;

b) the communicable disease presents a risk to the health of persons in the health unit served by me; and

c) the requirements specified in this Order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease.

I am also of the opinion that the delivery of notice of this Order to each and every member of the class is likely to cause a delay that could significantly increase the risk to the health of any person residing in the health unit, so notice shall be provided through the public media and the internet via posting on the DRHD website: https://www.durham.ca/en/health-and-wellness/novel-coronavirus-update.aspx.

NOTICE

TAKE NOTICE THAT each member of the class is entitled to a hearing by the Health Services Appeal and Review Board if the member has delivered notice to me and to the Health Services Appeal and Review Board, 151 Bloor Street West, 9th Floor. Toronto, Ontario, M5S 2T5, notice in writing, requesting a hearing within 15 days after service of this Order.

*At the time of this Order, all requests for appeals and reviews, submissions, materials, and inquiries must be sent to the Health Services Appeal and Review Board by e-mail to hsarb@ontario.ca or faxed at 416-327-8524. See: http://www.hsarb.on.ca/ for current information.

AND TAKE FURTHER NOTICE THAT although a hearing may be requested this Order takes effect when it is delivered to a member of the class or brought to the attention of a member of the class.

F3: COVID-19 Policies Windsor-Essex Region

Retrieved from Windsor-Essex County Health Unit. (2021).

WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

CLASS ORDER

Made pursuant to section 22(5.0.1) of the

Health Protection and Promotion Act, R.S.O. 1990, c.H.7, as amended

DATE: Updated **April 1st, 2021**

This order replaces the Class Action order issued to all owners and operators of agricultural farms in Windsor and Essex County on June 12, 2020.

TO: All owners and operators of agricultural farms in Windsor and Essex County who:

a. Employ temporary foreign workers (TFWs) in any capacity
b. Employ local workers or temporary help agencies (THA)
c. Participate in the federal Temporary Foreign Worker (TFW) program
d. Operate any model of seasonal housing accommodations

Under Section 22 (5.0.1) of the Health Protection and Promotion Act, a medical officer of health may make an order to a class of persons who reside or are present in the health unit served by the Medical Officer of Health to take or to refrain from taking any action that is specified in the order in respect of a communicable disease.

Based on data available to the Windsor-Essex County Health Unit, I am of the opinion that there is a high risk of increasing spread of COVID-19 within agricultural farms in Windsor and Essex County. The measures specified in this order are necessary in order to decrease or eliminate the risks to health associated with the COVID-19.

I, Dr. Wajid Ahmed, Medical Officer of Health, for Windsor and Essex County, ORDER YOU TO TAKE THE FOLLOWING ACTIONS, effective 12:01 a.m. on **April 2nd, 2021**:

Pre-Arrival of Workers

1. Submit Isolation/Quarantine Plans to the Windsor-Essex County Health Unit prior to any TFW arrival. The plan must include at a minimum the following information:
    a. First/Last name, as it appears on passport, with contact number and date of birth of all workers
    b. Date of arrival clearly indicated for each individual
    c. Site address where 14 day quarantine will take place
    d. Site address where self- isolation will occur
    e. 24/7 emergency contact for your organization
    f. Transportation plans from port of entry and for medical care

2. All living accommodations, including temporary isolation/quarantine housing for TFWs must be inspected and approved by the health unit prior to occupancy
    a. At no point in time shall TFWs be moved without notifying the Windsor-Essex County Health Unit
    b. Moves can only occur into an approved living accommodation
    c. Growers are required to obtain approvals from local municipal fire, building and by-law agencies prior to contacting the Windsor-Essex County Health Unit

During the 14-day Quarantine Period or Self –Isolation

3. Ensure that all TFWs are quarantined for 14 full days from the date of arrival
4. During the 14-day quarantine period, TFWs are not permitted to work
5. Conduct **daily health checks** of all individuals under quarantine or self-isolation
    a. Document all health checks and provide it to the health unit within 24 hours if requested
6. Accommodations for quarantine must allow for 2 metres at all times, if unachievable a separate room or alternate accommodation is required
7. Provide COVID-19 information and educational material to all new arrivals in their native language
    a. Post information about preventing the spread of COVID-19 in all entry ways, common areas, bathrooms and kitchens
    b. Post any information requested by the Windsor-Essex County Health Unit
8. Ensure that arrangements are made for the provision of food, water, laundry, cleaning supplies, hand soap, linens, personal protective equipment and alcohol based hand sanitizer
    a. Provide all receipts within 24 hours when requested
9. Meals provided must be nutritious and well balanced
    a. Employers must accommodate both cultural and dietary restrictions for workers
    b. Workers must be able to store food in a safe manner
    c. Potable water must be available at all times
10. Provide cleaning and disinfecting supplies for the purpose of cleaning and disinfecting the living space
    a. Provide training on how to use cleaning and disinfecting supplies
    b. A **cleaning log must be maintained** for all accommodations housing more than one (1) TFW
11. Ensure that there is a separate room or alternative accommodation available for isolation purposes
    a. If a worker becomes symptomatic at any time, the employer is required to immediately provide accommodations that enable the worker to be fully isolated from others
12. Ensure TFWs under quarantine or self- isolation are able to notify the employer if they become symptomatic
    a. Provide training on how to contact employer in the event of symptom onset

b. For greater clarity, employers are to group TFWs in the workplace based on their housing arrangements/residence. TFWs are to work with only the colleagues with whom they reside to the greatest extent possible

25. A complete and accurate list including first/last name, date of birth, address and phone number of all workers (TFW, local, permanent, temporary or contract) is to be made available to the Windsor-Essex County Health Unit upon request within 24 hours
26. Ensure that all employees current or future are exclusively working within one location
    a. All individuals who are employed with more than one employer must immediately limit this to one
    b. Ensure that any contracted employees including THA, are exclusively working for one workplace
        i. At no point in time shall THA or contract workers engage with TFWs
27. Maintain a list of all THA that are utilized both on and off farm. The list should include the following information and be made available within 24 hours of request from the Windsor-Essex County Health Unit or the Ministry of Labour, Training and Skills Development:
    a. Name of THA with contact and address
    b. First/last name of all THA workers that entered your facility
    c. Records of active screening logs from individuals that entered the workplace
28. Ensure full compliance with all legislative requirements to protect worker health and safety and any directions and guidance provided by the Windsor-Essex County Health Unit (health unit), Ministry of Labour, Training and Skills Development (MLTSD), Ontario Ministry of Agriculture Food and Rural Affairs (OMAFRA) and the Federal Government pertaining to COVID-19 are followed

TAKE NOTICE THAT each member of the class to whom this Order is directed is entitled to a hearing by the Health Services Appeal and Review Board if the member has delivered notice in writing to me (at the address below) and to the Health Services Appeal and Review Board (at 151 Bloor Street West, 9th Floor, Toronto, Ontario, M5S 1S4) requesting a hearing within 15 days after publication of this Order or otherwise in accordance with applicable law. In the context of the COVID-19 outbreak:

All requests for review, submissions, materials, and inquiries should be sent to the Health Services Appeal and Review Board by e-mail to hsarb@ontario.ca or faxed to the Board at 416-327-8524.

AND TAKE FURTHER NOTICE THAT although a hearing may be requested this Order takes effect when it is delivered to a member of the class or brought to the attention of a member of the class.

FAILURE TO COMPLY WITH THIS ORDER may result in further legal action being taken against you under sections 36(2), 35, 102 and other relevant provisions of the Health Protection and Promotion Act.

F4: Policies Niagara region

Retrieved from Niagara Region Public Health. (2021).

Niagara Region

CLASS ORDER

made pursuant to Section 22 of the Health Protection and Promotion Act, R.S.O. 1990, c.H.7

July 10, 2020

TO: All owners/operators of farms within the Niagara Regional Area who
1. Hire migrant farm workers in any capacity.
2. Employ temporary seasonal workers.
3. Participate in the federal Temporary Foreign Worker program (TFW).
4. Operate any model of seasonal housing accommodations.

I, Dr. M. Mustafa Hirji, Medical Officer of Health (Acting) for the Niagara Regional Area, order you under section 22 of the *Health Protection and Promotion Act* to take the following action(s):

1. Keep a list of names of all temporary workers employed by your farm, including any foreign workers who are scheduled to arrive in Canada, their planned date of arrival, and a plan for isolation of the workers.
2. Ensure that accurate and updated contact information for all persons who work at the farm (permanent, temporary, or contract), hereinafter referred to as "worker(s)", is available to be produced to Niagara Region Public Health within 24 hours of request. This should include all workers since April 1, 2020
3. Conduct daily interactive screening of all workers and visitors to the farm for symptoms of COVID-19, using the "COVID-19 Screening Tool" developed by Niagara Region Public Health, or another tool approved by Niagara Region Public Health. Answers to daily screens should be collected and retained for at least 6 weeks.
4. If a worker fails their daily screen, ensure the employee is able to isolate from other workers in a separate room or building; as well, provide assistance to the worker to be tested for COVID-19 if the worker consents to be tested.
5. Organize workers into teams (cohorts) of no more than 10 persons that work separately from other teams with no unnecessary interaction between teams during the work day. These teams should also be housed together to the extent possible, if they live in housing owned by the owner/operator of the farm. Cohorts should remain consistent over time, and changes to them occur infrequently and only if there is a substantial need for change.
6. Organize the work area to maximize the opportunity for workers to maintain a physical distance of 2 metres from others in their team at all times.
7. If the owner/operator is also the landlord for the workers, organize living areas such that there is at least 2 metres separation of all beds.
8. If the owner/operator is also the landlord for the workers, provide cleaning, hand washing, and disinfection products to the workers, and replenish supplies so that they do not run out.
9. Supply medical grade face masks to all workers, so that they can protect themselves and each other when 2 metre physical distance is not possible.
10. Supply additional face masks to all workers who reside on the farm or for whom the employer is the landlord, so that they can protect themselves and each other when at home.
11. Ensure that all workers are informed of and understand their rights and entitlements, including access to healthcare services and other supports that may be available if that worker becomes sick.

12. Advise Niagara Region Public Health if you learn that any worker has tested positive for COVID-19, if you suspect any worker has COVID-19, or if you suspect a COVID-19 outbreak.
13. Ensure that any worker who must isolate due to symptoms of COVID-19, being tested for COVID-19, or being a contact of COVID-19 receives full pay or a reasonable approximation thereof for the time they must isolate, either through the Workplace Safety Insurance Board or through any other arrangement of the choice of the employer.
14. Facilitate Quest Community Health Centre or another provider endorsed by Niagara Region Public Health in any request to offer health assessments or health care to workers.
15. Follow all guidance by Niagara Region Public Health, the Government of Ontario, or the Government of Canada as pertaining to preventing infections and spread of COVID-19.

THE REASONS for this ORDER are that

1. COVID-19 is a potentially fatal infectious disease, currently constituting a worldwide pandemic.
2. COVID-19 is a communicable disease that can spread readily to others.
3. Agricultural farms that employ temporary foreign workers have been the site of many large outbreaks of COVID-19 in Ontario as well as elsewhere in Canada.
4. At least 3 temporary foreign workers have died as a consequence of COVID-19 in Canada.
5. The housing of temporary foreign workers often has a high density of persons resident in a comparatively small space, lessening opportunities for physical distance and therefore being a higher risk setting for the transmission of COVID-19.
6. The workplace of a farm sometimes involves work in closed spaces (e.g. greenhouses) where opportunities for physical distance are lessened, and the risk of transmission of COVID-19 is therefore greater.
7. Temporary foreign workers experience multiple social barriers, including language and cultural barriers, that lessen their access to health care and prevention, increasing the risk that COVID-19 infections may not be diagnosed in a timely manner, and outbreaks may occur.

I am of the opinion on reasonable and probable grounds that

1. A communicable disease exists or may exist or there is an immediate risk of an outbreak of a communicable disease in the health unit served by me;
2. The communicable disease presents a risk to the health of persons in the health unit served by me;
3. The requirements specified in this order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease.

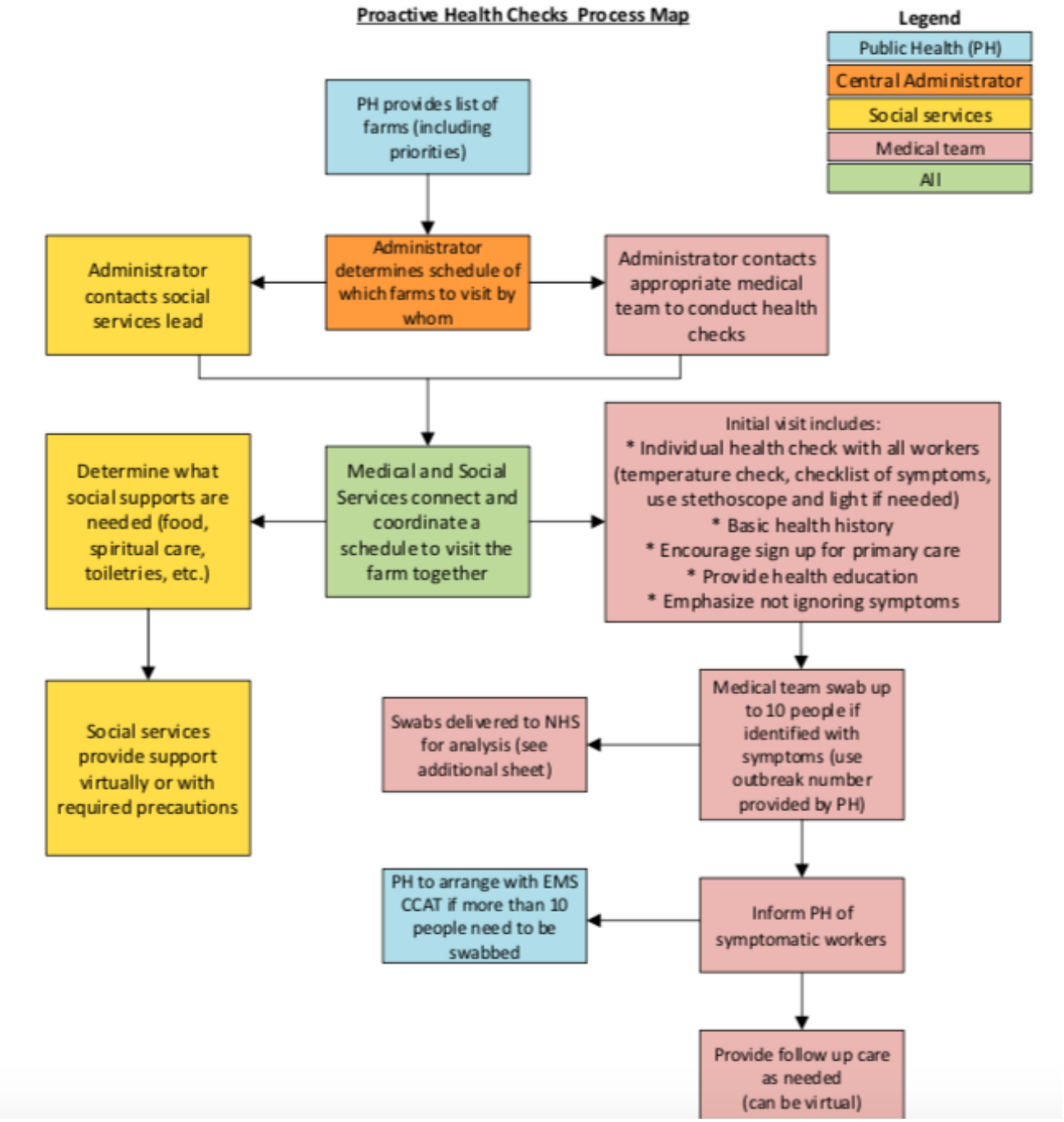
NOTICE

TAKE NOTICE THAT you are entitled to a hearing by the Health Services Appeal and Review Board if you deliver to me and to the Health Services Appeal and Review Board, Health Boards Secretariat, 151 Bloor Street West, 9th Floor, Toronto, Ontario, M5S 2T5, notice in writing, requesting a hearing within 15 days after service of this Order.

AND TAKE FURTHER NOTICE THAT although a hearing may be requested this Order takes effect when it is served upon you.

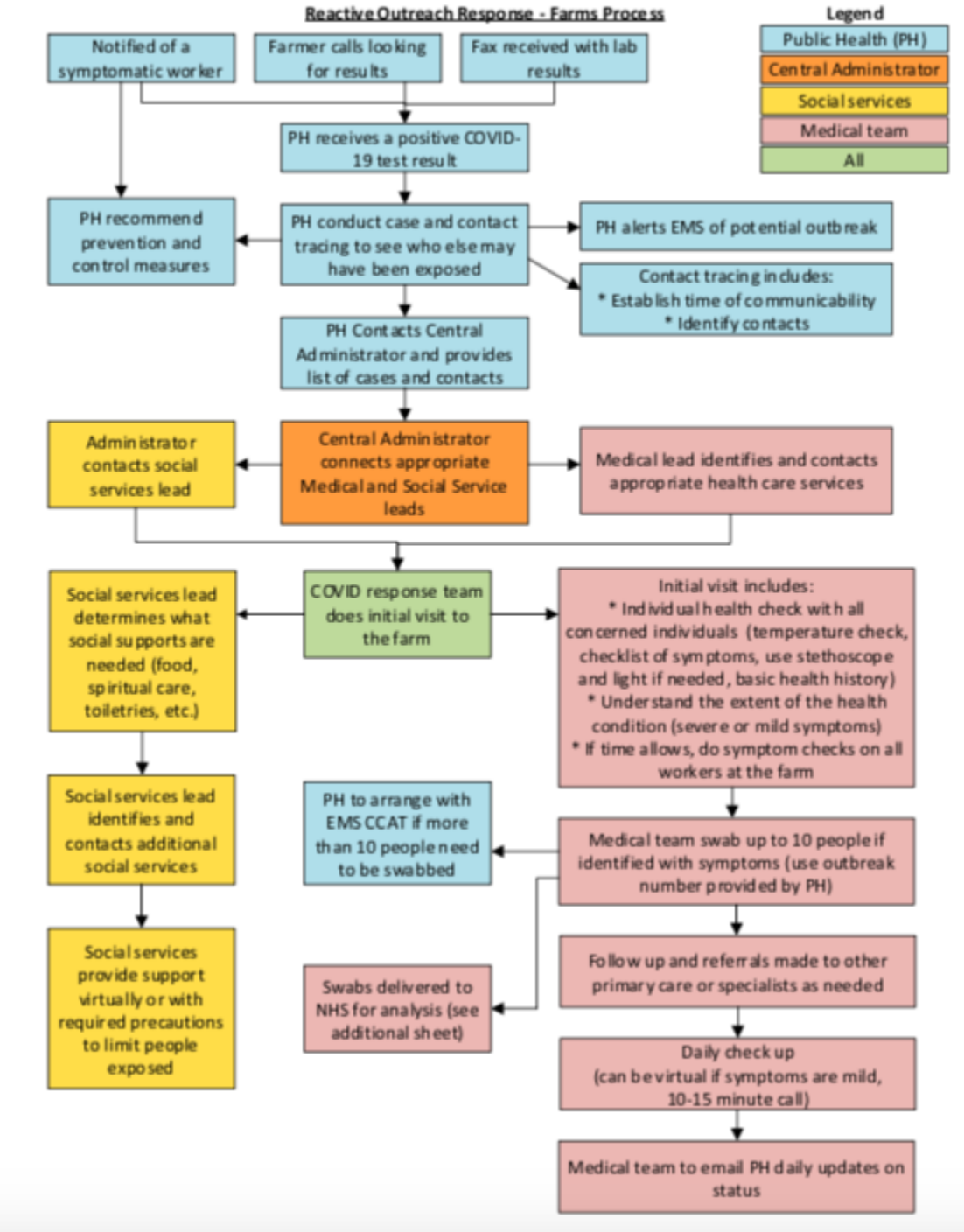
F5: Proactive Health Checks Process Map

Retrieved from Quest Community Health Clinic. (2021).



F6: Reactive Outbreak Responses

Retrieved from Quest Community Health Clinic. (2021).



F7: Temporary Migrant Workers Community Resource

Retrieved from Durham Region Public Health. (2021).

Housing Concerns / Complaints

All migrant farm worker housing is inspected by the Durham Region Health Department prior to worker arrival. If you have any questions or concerns about your housing conditions, call the Durham Region Health Department at 1-800-841-2729 or 905-668-2020 to speak to a public health inspector.

Worker's Right

Workers have the right to refuse unsafe work. If health and safety concerns are not resolved internally, a worker can seek assistance by filing a complaint with the Ministry of Labour's Health and Safety Contact Centre at 1-877-202-0008.

Health & Community Services

Ontario 211
Provides information on and referrals to Ontario's community, social, health-related and government services. Call 2-1-1 or visit 211ontario.ca.

Telehealth
1-866-797-0000
Telehealth is a free, confidential service you can call to get health advice or information 24 hours a day. Assistance is available in other languages.

OHIP Health Benefits

Your employer should have your OHIP card ready for you soon after your arrival to your place of employment.

Consulate / Liaison Offices

Barbados
416-214-9805
toronto@foreign.gov.bb
110 Sheppard Ave. E., Suite 205, Toronto

Guatemala
416-994-3060
opalma.gt.consultoronto@gmail.com
4 Kingsboro Road, Thornhill

Jamaica
416-733-4358
info@jcgtoronto.ca
303 Eglinton Ave E, Toronto

Mexico
416-368-2875 ext. 239, 232, 230,271
Carlos Herrera
cherrera@sre.gob.mx
Manuel Balderas
ptattor02@sre.gob.mx
11 King St W #350, Toronto, ON

Thai
613-853-2650
consular@thaiembassy.ca
31 Gloucester St, Toronto, ON

Trinidad & Tobago
416-495-9443
185 Sheppard Ave W, North York

DURHAM REGION HEALTH DEPARTMENT

Durham Health Connection Line
905-668-2020 or 1-800-841-2729
durham.ca/health

If you require this information in an accessible format, contact 1-800-841-2729.

Feb 2021

Durham Region

Welcomes You

Temporary Migrant Workers Community Resource