

**Key Findings and Recommendations from a Study of Coroner's Files of
Migrant Agricultural Workers' Deaths in Ontario from January 2020 to June 2021**

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Study Background:

The emergence of COVID-19 has given rise to new health risks and challenges throughout the world. Within the Canadian context, migrants working as temporary foreign workers in agriculture and food processing have been disproportionately affected. Citing long-standing barriers to health, in addition to various social and legal vulnerabilities, numerous experts and advocates raised the alarm at the start of the pandemic, predicting that this group would face heightened risks from COVID-19 (Caxaj et al. 2020; Haley et al. 2020; Keung 2020; Vosko and Spring 2020; Weiler et al. 2020). Between 2020 and 2021, migrant agricultural workers in Canada faced much higher infection rates than most workforces (Landry et al. 2021; Mehler Paperny 2021). During this time, nine migrant agricultural workers died in Ontario alone, with additional deaths reported in other regions of Canada.

Our research team, consisting of medical doctors, nurses, and academics with decades of experience regarding the health and human rights of migrant agricultural workers in Canada, several of whom participated in a death review carried out by the Deputy Coroner of Ontario in 2020-21, conducted a research study to identify (a) common and divergent medical issues and trajectories, as well as (b) social determinants and resources available to migrant agricultural workers that may help explain the context, and/or may have contributed to the deaths of these nine individuals during the 2020 and 2021 seasons. This qualitative study included the review of coroner files for the nine individuals who died in Ontario within this timeframe and a media scan of sources that reported on the deaths of these individuals to further contextualize this data. The larger goal of this study is to develop evidence-informed practises and policy changes aimed at preventing the deaths of more migrant agricultural workers. Yet, as we prepare this report for publication, we are aware that several migrant agricultural workers have already died in Ontario during the early weeks of the 2022 season (CBC News, 2022). While the deaths of the individuals we have investigated, as well as those that have occurred this year, are not all related to COVID-19, it is notable that deaths continue to occur during the quarantine period.

Summary:

Our research into the deaths of migrant workers in Ontario has uncovered the following key findings: (1) a heightened risk of travel, and missed opportunities for proactive testing, suggesting the need to modify testing frequency and modality to better address workers' COVID status; (2) the quick deterioration of some individuals' health status, suggesting a need for more intensive monitoring and more proactive testing; (3) inconsistent quarantine conditions with limited oversight, creating heightened risks for infection among workers, making clear the need for several points of intervention; (4) at times, ad hoc and limited standardisation of daily check-ins for workers, and in some cases, a concerning reliance on employers to monitor migrant agricultural workers' symptoms; (5) profound barriers for workers to both access and navigate the health care system, causing delays in workers receiving timely emergency care and treatment, with some workers dying alone in isolation; (6) heightened risk of COVID-19 and/or medical complications because of workers' short temporary contracts (e.g., through need for departure and re-entry into Canada), and potential risks posed by the timing of vaccination (e.g.,

upon arrival at airport); (7) lack of clarity about whether all families of the deceased have been provided necessary support to access eligible workplace compensation, and provincial agencies' definition of "work site" (e.g., quarantine quarters), that may have implications both for workplace compensation and health and safety investigations; (8) limited documentation about contact tracing, social supports and resources available to migrant agricultural workers and contact tracers, pointing to opportunities for greater collaboration across co-investigative agencies and health services; and (9) broader vulnerabilities as a result of unauthorised and/or temporary status, geographic and social isolation, poorly lit roads and inadequate housing and living conditions, illustrating the day-to-day context that limits and disadvantages this population in staying safe and accessing timely medical care.

Below, we outline recommendations in light of each of these findings. Among them, we recommend medically comprehensive and culturally appropriate check-ins with migrant agricultural workers that ensure open lines of communication and partnerships with support organizations who have a track record of working with this population. Investment in resources and strategies to address common barriers faced by this group as well as policy reform that enables stronger oversight, enforcement, and mitigates the structural vulnerability faced by this population is required. Regional, provincial and federal agencies all have a role to play to address the vulnerabilities that have become inherent to the way in which migrant agricultural workers live and work in Canada, and their limited opportunities to access independent and timely medical care. Reconsideration of migrant agricultural workers' legal status should be part of a strategy to address the root causes that are impeding workers' rights to health and safety during their time in Canada.

Section I: COVID-19 Surveillance, Quarantine, Isolation, and Access to Health Services

1. Finding:

Temporary foreign workers coming to Canada during this period had to test negative for SARS-CoV-2 prior to departure, and were tested again upon arrival to Canada, yet some tested positive shortly after arrival. This suggests that the timing, type, or frequency of testing¹ may need to change to provide a more accurate assessment of migrant agricultural workers' COVID-19 status. Furthermore, it is possible that individuals contracted SARS-CoV-2 during their travel, including at the airport or during transport to their sites of quarantine.

Recommendations:

- (a) Implement measures to minimize exposure to SARS-CoV-2 during travel to and from Canada (i.e., by air) and transportation within the receiving country (i.e., shared vehicles - cars, bus, train etc.), taking into account the significance of airborne transmission. These measures should include the provision of, at minimum N95 or KN95 masks, or their equivalent, with instructions on their use (see also Section II).
- (b) Provide accessible, independent (i.e. not through a private contractor) mobile testing for migrant agricultural workers at regular intervals during quarantine. Migrant workers should have access to testing strategies that match their risk and symptoms, including rapid antigen tests (e.g., agri-food employers participating in the Provincial Antigen Screening Program) and PCR tests.

2. Finding:

Several workers' illness trajectory worsened very quickly; in some cases, they died days after test results confirmed that they were COVID-positive. Workers may have benefited from more intensive monitoring after testing positive for SARS-CoV-2 so that clinical deterioration could be identified and intervened upon. In addition, with greater access to testing, infection with SARS-CoV-2 may have been detected earlier in the illness trajectory and allowed for better monitoring and treatment.

Recommendations:

- (a) Migrant agricultural workers should be targeted for regular mobile testing coordinated by public health units, assessment centres and/or other health care providers in order to address common social isolation, health care service barriers and workplace compensation requirement needs (Minnings 2021; Caxaj & Cohen, 2019). Migrant agricultural workers should also have regular access to rapid antigen tests, with consistent access to PCR testing in the event that a worker tests positive or becomes symptomatic.
- (b) Workers in quarantine should receive standardized health assessments. These assessments should examine both objective (e.g., temperature reading, pulse oximeter) and subjective (e.g., sore throat, chest pain, shortness of breath) indicators of health status, involve direct communication with the migrant agricultural worker (rather than an employer), and be performed at regular intervals by health care professionals with

¹ A negative COVID test within 72 hours of departure was accepted in many cases, leaving time for workers to contract SARS-CoV-2 during travel. To illustrate, Jamaican workers often brought negative tests from around the island with them to Kingston, where they all congregated en masse before flying out.

professional interpreters and/or trusted support persons/specialized staff with a track record of working with migrant agricultural workers (see also 4b).

- (c) This population should be provided with accessible information about symptoms that require further assessment by health care professionals, and specific contact information and resources (e.g., how to call an ambulance, contact info for nearest hospital) to report these concerns.

3. **Finding:**

Living arrangements during the quarantine period varied, and often, workers shared living units with co-workers during this time. Since some workers did not test positive for SARS-CoV-2 until after their arrival, it is possible that they were infected by a co-worker as a result of inadequate quarantine conditions.

Recommendations:

- (a) Clear and consistent guidelines should be put in place for the quarantine period that allow for physical distancing, including robust standards that account for the size of living quarters and common areas (for a discussion of the positive impact of stricter bunkhouse requirements see Vosko & Spring, 2020).
- (b) High standards for ventilation (i.e., open windows, HEPA filters, maintenance of HVAC systems, etc.) should be developed, communicated, and enforced to ensure the safety of workers during the quarantine period.
- (c) Regular oversight and adequate investment should be provided for public health units to inspect quarantine conditions (Caxaj & Cohen, 2021a), or alternatively, provincial leadership to standardize and ensure the highest level of health and safety during the quarantine period. A clear commitment by regional and provincial authorities to share information, and coordinate enforcement mechanisms for more comprehensive oversight with federal agencies that oversee migrant workers in agriculture, should also be put into place (MWH-EWG, 2020).

4. **Finding:**

Symptom monitoring was sometimes delegated to employers. This is both unethical and inappropriate as it can pose barriers to workers' access and quality of health care (Colindres, Cohen & Caxaj, 2020; Cole et. al, 2019; Hennebry, McLaughlin & Preibisch, 2016; McLaughlin & Tew, 2018). At times, it was unclear to what extent workers received health assessments, and whether these were performed by telephone or in-person, and whether or not they were carried out by health care professionals.

Recommendations:

- (a) Culturally and linguistically appropriate health assessments, carried out by (or in partnership with) health care professionals, must be standard protocol for workers during the quarantine period. Health care professionals should be equipped to evaluate the appropriateness of quarantine (e.g., adequate food, washrooms, social distancing), provide referrals for other health-related concerns, and assess the individual's ability to call for emergency medical services (e.g., specific address/location information is available to workers).
- (b) Health assessments should use both subjective (e.g., sore throat, chest pain, shortness of

breath) and objective (e.g., temperature reading, pulse oximeter) indicators of health status to ensure a timely response if a worker's condition were to deteriorate. Furthermore, assessments should be carried out through direct communication with migrant workers (rather than an employer) in their preferred language with the use of professional interpretation. (For further discussion on common health service barriers and recommendations see Caxaj & Cohen, 2021a; MWH-EWG, 2020).

- (c) To address issues that may contribute to delays in treatment, workers should be provided with education upon arrival about how to escalate health concerns to the appropriate parties and contact information for hospital and emergency medical services (see also 4a & 4b).

5. **Finding:**

Several workers died during the quarantine period. In some cases, access to emergency medical care was delayed due to miscommunication, a lack of understanding of how to navigate the health care system, and/or limited health literacy. In one case, an ambulance was delayed as they were dispatched to the wrong address. In another case, emergency hospital treatment was delayed because a worker declined an intervention fearing they would have to pay.

Recommendations:

- (a) Workers' addresses should be clearly posted in their place of residence, along with instructions in their preferred language(s) of how to call emergency medical services.
- (b) Workers should be reassured, in culturally appropriate ways (i.e. in languages and terms that they understand), that emergency care, especially in the COVID-19 context, is not associated with a fee or loss of employment. Any existing fees for emergency treatment that are currently not free of cost for this workforce should be systematically waived.
- (c) Workers should be familiarized with their entitlement to health care while working in Canada (e.g., provincial health care entitlements and supplemental private insurance coverage). In the clinical setting, perceived financial concerns should be proactively addressed with this workforce (e.g., fees for service) to prevent delays in consent for emergency treatment.
- (d) Dedicated service providers/supports (e.g., outreach workers, support organizations) can conduct comprehensive assessments of workers' mental, emotional, and physical wellbeing, and uniquely build trust that can provide insight into medical concerns. Given this population's limited trust and knowledge of the health care system (Caxaj & Cohen, 2019; Colindres, Cohen & Caxaj, 2020; McLaughlin & Tew, 2018), support persons/specialized staff are key partners in helping workers navigate the system (Caxaj & Cohen, 2021b).
- (e) All migrant agricultural workers whose preferred language is not English should have immediate and ongoing access to professional interpretation for the duration of their medical care, including outpatient and in-hospital care.

6. **Finding:**

Some workers died while self-isolating. Some health units reported providing written information and/or regular phone calls to workers. However, there was no standard preemptory protocol; nor was there evidence of consideration of workers' varying

degrees of knowledge of critical changes in their health status.

Recommendations:

- (a) Several strategies must be in put in place to ensure timely medical responses and follow-up for this population while in self-isolation similar to during quarantine periods (5a – 5e). Lack of knowledge and/or familiarity with how to navigate the health care system must be anticipated and addressed *prior* to the person’s condition deteriorating. Clear and accessible information should be delivered in both written and audio-visual formats to explain how to access emergency medical care if symptoms worsen, anticipating the possibility of health literacy barriers. As in the initial quarantine period, and subsequent quarantines in instances of exposure (i.e., illness among close contacts), medical assessments should be standardized, occur regularly, and be carried out in workers’ preferred language throughout this group’s time in Canada. Objective measures should be included to complement individuals’ self-reports (see also 2b and 4b).
- (b) Culturally and linguistically appropriate medical assessments should be performed when workers are self-isolating. Clinicians conducting assessments should inform workers about how to access emergency medical services, and screen for inadequate isolation conditions (akin to quarantine conditions under points 4a to c).
- (c) Telephone calls, video and/or in-person assessments during the self-isolation period should be carried out in partnership with health care professionals and support persons/specialized staff who are from the individual’s cultural community, and have mastery of the worker’s preferred language (if this skill-set is not held by the health care professional). This collaboration can help improve communication and workers’ ability to report symptoms and changes in their medical status (Caxaj & Cohen, 2021b; McLaughlin & Tew, 2018).

7. Finding:

Some individuals did not have access to care in their preferred/first language once hospitalized. This likely made it difficult for workers to communicate their needs and navigate the health care system (see also point 5 above).

Recommendations:

- (a) The province should require that hospitals and public health units provide access to professional interpretation and translation services. A clear commitment to the provision of language-concordant health care for migrant agricultural workers is needed. This would include written information about SARS-CoV-2 in this group’s preferred language as well as access to telephone, video, or in-person interpretation services on an ongoing basis.
- (b) Hospitals and public health units should institute protocols and/or ensure the implementation of universal access to professional interpretation and translation services for all clients whose preferred language is not English.
- (c) Emergency, Intensive Care Unit and other hospital clinicians should be educated and provided with timely resources and comprehensive training about how to (a) assess and identify language needs; (b) determine an individual’s language preference and (c) arrange for professional translation and interpretation services.
- (d) Hospitals and public health units should partner with organizations with a history of

supporting migrant agricultural workers to enable this population to navigate an unfamiliar health care system and support them in advocating for their needs. For example, through referrals to support organizations, dedicated staff can help this population advocate for their need for an impartial interpreter and help patients voice their questions or concerns about treatment (Hennebry et al 2020).

- (e) Physicians, nurses, and allied health care professionals should be educated about the unique barriers faced by this population, and should be made aware of and be responsible for referrals to community resources that can provide further orientation and support (Caxaj, Cohen & Marsden, 2020; Colindres, Caxaj & Cohen, 2020).

Section II: Airport and Travel Considerations

1. Finding:

In at least two cases, workers entered Canada twice in the same year to work at different farms, putting themselves at greater risk for exposure to SARS-CoV-2 through international travel.

Recommendation:

- (a) As noted above (see part 1, 1a), protective measures must be in place for when migrant agricultural workers travel to minimize exposure of SARS-CoV-2.
- (b) Federal and provincial governments should work together to improve the ease of transfers within and across provinces. The federal government should reconsider the duration of work permits to help this workforce limit their exposure to risk through international travel. This is appropriate given that some migrant agricultural workers may only spend a few months or less time in their countries of origin before returning to work in Canada again.

2. Finding

Several workers were vaccinated at the airport upon arrival/re-entry into Canada. While the charts reviewed do not provide information about these workers' specific experiences in this regard, the overall conditions² of airport vaccination may compromise the quality of voluntary and informed consent for vaccination for this population (Canadian Press 2021).

Recommendation:

- (a) Rather than being offered vaccination at the airport, migrant agricultural workers should be approached for vaccination at a later date by mobile health teams who can take the time to answer their questions in an atmosphere that is relaxed and non-coercive, and ideally immediately following their quarantine period and before their arrival at farms. This approach could also serve to improve access and lines of communication for workers, who are often unfamiliar with the health care system. Welcome and greeting time at the airport should be used to inform workers of next steps regarding their health

² Several support organizations and migrant agricultural workers reported being fatigued, hungry, and not in overall optimal physical or mental conditions upon arrival, at the time that they were approached for vaccination at the airport. In addition, international travel may expose individuals to SARS-CoV-2.

care in Canada (e.g., vaccinations, testing, options, monitoring), coverage and entitlements, and workers' compensation (see Section III).

Section III: Workers' Compensation and Defining the Worksite

1. Finding:

It is unclear whether the families of individuals whose deaths are within the purview of the provincial workers' compensation board (WSIB) had access to information and a clear path for pursuing all eligible compensation. Given the widespread limited awareness of this population's extensive coverage,³ indeed, it is possible that deceased individuals' families were not provided with adequate information to claim compensatory entitlements. Most files do not provide any information in this regard.

Recommendations:

- (a) Workers, and, when deceased, their next-of-kin, must be made aware of WSIB eligibility, and be given the opportunity to connect with legal advocates who can assist with WSIB applications.
- (b) All migrant agricultural workers' deaths should be flagged for potential eligibility for WSIB. A specific agency should be tasked to liaise with the WSIB, next-of-kin, and if the family wishes, legal advocates (e.g., the Industrial Accident Victims Group of Ontario) as necessary who can confirm whether coverage is applicable and support next-of-kin through the process. The coroner's investigation can serve as a final appraisal that such mechanisms have been put in place.
- (c) Next-of-kin of the deceased should be provided with access to professional interpretation and/or support person/specialized staff to aid them in navigating compensatory channels.
- (d) Physicians and allied health care professionals should receive training regarding the broad eligibility of WSIB coverage for this workforce to ensure that reportable deaths and injuries are reported in a timely manner, and that next-of-kin can access compensation to which they are entitled. (See Colindres et. al, 2020, Caxaj et. al, 2020, Hennebry et. al, 2016 and McLaughlin et al, 2014, for further discussion of barriers to accessing workplace compensation).

2. Finding:

Blurred lines between what constitutes a worksite and place of residence require explicit consideration in establishing what constitutes a workplace death or injury, especially during the COVID-19 pandemic, a period in which workers' living conditions during quarantine have been arranged and often overseen by employers. For example, in some cases, reports

³ The WSIB provides [extensive coverage](#) for foreign agricultural workers, as stated in their policy: "Coverage begins as soon as workers reach the agreed-upon point of departure in their homeland, and remains in place until they return to their country. While travelling in Ontario, these workers are covered when (i) in transit from an airport in Ontario to the employer's premises and/or; (ii) using a means of transportation authorized by the employer, and; (iii) following a direct and uninterrupted route to or from the employer's premises. . . In addition to coverage while in the course of employment, workers are also covered during periods of leisure, meals, and while sleeping in employer-provided quarters."

from the Ministry of Labour indicated that workers had “not reported to work yet,” although workers were residing in an employer-organized quarantine site.

Recommendations:

- (a) The Ontario government should clearly define employer-provided accommodation, including quarantine and isolation accommodations, as encompassing the worksite, and therefore, deaths among this group as “work related.” This will address the fact that living conditions are outside of workers’ control, especially (but not strictly) during the quarantine period.
- (b) All migrant agricultural workers’ deaths should be automatically investigated for potential work-related associated factors. This is essential for a comprehensive root cause analysis of these workers’ deaths, whose only reason to be in Canada and in their unique situation is because of work demands.

Section IV: Reporting and Documentation of Death Trajectories of Migrant Agricultural Workers

1. Finding:

No contact tracing information was provided in any of the coroner’s reports suggesting a lack of information-sharing in this regard on the part of public health units.

Understanding likely sources of infection can help identify effective public health interventions and areas for improvement. Given migrant agricultural workers’ vulnerability in their living and working environments, it is important to understand direct sources of exposure in the transmission of SARS-CoV-2 for this population.

Recommendations:

- (a) In the context of the COVID-19 pandemic, public health units should work closely with coroners and other co-investigative agencies so that investigations of the deaths of this workforce include information about vaccination status, testing, possible sources of exposure to SARS-CoV-2, and illness trajectory, as available. Attending hospital staff and/or emergency responders who last care for deceased migrant agricultural workers should work with the coroner to identify and report relevant factors that may be associated with known infection or exposure to SARS-CoV-2.

2. Finding:

Very few files contained information about the social supports and communication tools available to migrant agricultural workers, particularly during self-isolation/quarantine. Socio-cultural considerations did not appear to be considered in most files despite the fact that barriers of this nature may have shaped the illness trajectory of some of the deceased.

Recommendations:

- (a) Consideration of this population’s social/geographic isolation, language barriers, international travel, and workplace and living conditions should be part of death reporting. Attending clinicians and coroners should work together to identify and document these factors to ensure relevant issues are identified in the death investigation. A social determinants of health framework (Paremoer et. al, 2021) may be useful to adopt

in the reporting of each death, given the various structural vulnerabilities faced by this group.

- (b) Further investigation is required to review how migrant workers access and communicate with emergency medical services, public health unit staff, and others. Provincial governmental agencies should systematically assess workers' access to professional language services and support services/specialized staff that may have influenced workers' health status. The coroner can also ask employers and co-workers of the deceased about the social supports and communication tools available to migrants in agriculture (e.g., connection to family/community organizations and access to mobile phone, landline, internet), in order to better assess barriers and facilitators to timely care.
- (c) Health care professionals should be educated about the precarious employment status of migrant agricultural workers, and the related power differential between employers and workers, which may contribute to delays in seeking care, or shape dynamics during health care interactions (Caxaj & Cohen, 2021b; Caxaj & Cohen, 2019; Hennebry et al. 2016; McLaughlin and Tew 2018; McLaughlin et al. 2018). Awareness on the part of the coroner's office and co-investigative agencies should be fostered in order to effectively investigate this dynamic. Knowledge in this regard can help guide both how the death investigation is conducted (e.g., in terms of who is interviewed), and what factors are further explored (e.g., how health screenings are carried out).
- (d) Coroners' offices and co-investigative agencies should consider a standard practice of gathering data from co-workers (rather than only from employers or supervisors), family members, and health care professionals, as each may provide a unique perspective and individually, only offer partial information. When interviewing family members, coroners should consider the potential cultural norms and migrant agricultural workers' motivation to potentially conceal the severity of their conditions from their loved ones, which may prevent family members from providing a comprehensive medical history (e.g., if the individual's condition was deteriorating).

3. **Finding:**

Coroner reports often described medical care provided to migrant agricultural workers but did not contain copies of the referenced medical documentation. While we understand that the coroner's office is not a custodian of medical files, an absence of medical files raises questions about clinical decision-making and possible opportunities for earlier intervention, as well as potential systemic barriers to care that cannot be fully addressed.

Recommendations:

- (a) For the purpose of providing further clarity, the coroner's office should work closely with the research team reviewing these files to identify key documents that will provide further clarity on issues of concern, and act as a liaison with other health care agencies as required.

Section V: Broader Conditions and Factors at Play in Migrant Agricultural Workers' Health Status

1. Finding:

For migrant agricultural workers who are not employed on a temporary foreign worker contract, undocumented status can result in a climate of coercion that puts them at heightened risk of unsafe and exploitative living and working conditions.

Discussion:

A large body of research shows that relationships with a temporary help agency, especially in the case of triangular employment relationships (e.g., those in which an agency/ intermediary is involved), can intensify fear of reporting poor living and working conditions and make it more likely that this workforce, especially those migrant agricultural workers that are undocumented will accept a high degree of risk, including within the COVID-19 context (Vosko 2000, 2013).

Many recruiters are 'fly-by-night' operations, and many operate beyond provincial/national borders – two features that make accountability challenging. It is also extremely difficult to punish the actors behind the corporate shield (e.g., directors of corporations abroad). Under the Occupational Health and Safety Act (OHSA), temporary help agencies are treated as employers, jointly liable for the health and safety of workers placed with the client. However, agencies' specific obligations stem from the general duties of employers. In other words, under the OHSA, no express thought is given to what their specific obligations should be. Under the Employment Standards Act (ESA), joint and several liability also prevails with respect to wages (Vosko 2010). Furthermore, individuals without authorization to work are also less likely to understand that they are entitled to certain rights to health and safety, like other workers in Canada.

Recommendations:

- (a) Given the veritable fears of reprisal confronting migrant agricultural workers, especially those whose residency status is most precarious (e.g., those workers who are undocumented and/or with expiring contracts seeking to return annually), which may prevent them from reporting unsafe and unlawful working and living conditions, legislators should amend the OHSA by setting out the duties of agencies/recruiters with respect to OHS (Vosko 2019). Enumerating such responsibilities could help make agencies/recruiters and other parties to triangular relationships liable for their conduct.
- (b) To enhance enforcement of both occupational health and safety and employment standards protection, an extensive well-resourced regime of targeted proactive labour/employment standards and health and safety inspections is required to address the precarious conditions of employment often faced by this group that make it unlikely that they will complain. Previous research in Ontario supports this recommendation (Vosko et al. 2019, Caxaj & Cohen, 2019) as does a December 2021 [Report of the Auditor General of Canada](#) which highlights the pressing needs/deficiencies at the federal level, and provincial level (Tucker and Vosko 2021). Employers who hire migrant agricultural workers through agencies/recruiters should be the top priority for both Occupational Health and Safety & Employment Standard inspection, which must include blitzes and

targeted inspections.

- (c) The Coroner's office and collaborating agencies should support efforts to investigate whether provisions of Ontario's Employment Standards and Occupational Health and Safety Acts applicable to temporary help agencies/recruiters and client firms/employers have been enforced, including those on anti-reprisal and joint and several liability with respect to wages.
- (d) Efforts to ensure the health and safety of all workers should include measures to ensure undocumented workers (those without authorization to work) receive clear messaging about their rights to minimum employment standards protections and health and safety as well as health care.

2. **Finding:**

Remote neighbourhoods with poorly lit roads may create dangerous working conditions for migrant agricultural workers. These conditions of isolation heighten their risk both on and off the job (Caxaj & Diaz, 2018). In the case of at least one individual worker, this was a central factor that contributed to their untimely death. Factors related to both social and geographic isolation appeared to contribute to several individuals' ability to seek timely medical care.

Within the COVID-19 context, migrant agricultural workers must seek help from an overtaxed health care system that is less able to quickly respond, creating more challenges for them to receive timely medical care.

Recommendations:

- (a) There should be investment in regional transportation plans that account for migrant agricultural workers, and seek to address isolation faced by this group, and also provide road safety infrastructure to protect this workforce from nearby traffic.
- (b) Proactive relationship-building by primary care and public health unit departments should be initiated, so that familiarity and trust is built prior to a health emergency. Prior relationship-building can also provide an alternative method to communicate and plan preventive measures directly with this workforce, rather than through employers (Caxaj & Cohen, 2021b; Caxaj & Cohen, 2021c).
- (c) There should be investment in social support services and health care navigators that can help address obstacles that this population faces when seeking health care.
- (d) Regional and provincial governments and their delegates should develop resources and materials that can provide guidance to workers on how to navigate health care systems that are specific enough for the regional environments in which workers find themselves. To ensure this local relevance, partnerships with municipalities, civil society organizations and other regional bodies are required.

3. **Finding:**

Across several reviewed cases, media reports featured accounts of co-workers and service providers characterizing migrant agricultural workers' living conditions, including quarantine and isolation facilities, as inadequate (CBC News 2021; Mojtehdzadeh 2021; Rodriguez 2021). In some cases, these migrant workers, and persons in supportive roles to them, described a workplace environment in which health symptoms were discounted or not taken

seriously. These factors created further obstacles for a population who sometimes lacked knowledge or familiarity with the health care system (as noted above). The length of time each individual worker was employed in agricultural programs varied from their first year to multiple decades. Family members reported that their loved ones were motivated by a desire to provide an income for family members back home.

Discussion:

Research shows that a global context of inequity often creates a coercive context in which groups may feel forced to protect their livelihood over their health and wellbeing (OECD 2020). Combined with structural characteristics of temporary migrant agricultural worker programs (e.g., tied work permits, re-entry in the program contingent on employer nomination, lack of permanent residency), migrant agricultural workers often experience undue pressure to underreport critical issues, delay, and/or not seek medical attention or help with other concerns (Caxaj & Cohen, 2019; Hennebry et. al, 2016).

Recommendations:

- (a) To improve living conditions for workers and safeguard their health and safety, a federal housing standard should be established and enforced for the Seasonal Agricultural Worker Program (SAWP) and all other agricultural workers coming through the Temporary Foreign Worker Program's primary agriculture streams (Baxter 2021). The National Housing Standard should align with recognized standards for housing and related infrastructure, specifically the right to adequate housing without discrimination based on international human rights standards, outlined by numerous internationally agreed upon UN conventions and treaty bodies (on which many Canada is a signatory). The National Standard should, further, adhere to the Guidelines for the Implementation of the Right to Adequate Housing (2019) provided by the UN Special Rapporteur on adequate housing, who articulates that "specific protective measures and remedies are required for migrant workers living in housing provided by employers."
- (b) Aligned with the Deputy Chief Coroner's Review of three migrant agricultural workers' deaths, regional, provincial and federal governments should invest in more culturally informed and reliable mechanisms for migrant agricultural workers to both access timely medical care, necessary medical follow-up and assessment, and report workplace abuses and/or violations of human rights. Proactive health care protocols should be in place to anticipate commonly known barriers for this population to access and navigate health care systems, including, but not limited to, language barriers, health literacy challenges, geographic isolation, racism in health care, fear of deportability and employer gatekeeping (Colindres, Cohen & Caxaj, 2021; Caxaj & Cohen, 2019; Cole, et. al, 2019; Hennebry et al. 2016; Mayell and McLaughlin 2016; McLaughlin and Tew 2018; McLaughlin et al. 2018).
- (c) As supported by [decades of research](#), and as underscored by the auditor general's review of federal inspections, federal agencies should provide leadership and a commitment to more robust oversight and enforcement of health and safety, human rights and employment standards for migrant agricultural workers. Provincial and regional governments should work closely with federal agencies to oversee and enhance necessary oversight measures and sharing of critical information that can prevent life-threatening and health-harming conditions often faced by this population. These strategies should

include the launch of more on-site and unannounced inspections that involve direct communication with migrant workers in their preferred languages, using methods that are culturally appropriate, and that ensure meaningful participation and proactive measures to protect against reprisal.

- (d) To address underlying structural vulnerabilities that influence migrant agricultural workers' ability to seek medical care, report issues of concern, and advocate for their own health and safety (Hennebry et al. 2016; Mayell and McLaughlin 2016), there should be changes in the administration and nature of Canada's Temporary Foreign Worker Programs. Such changes should include, at minimum, more accessible/worker-centred options for work transfers and open work permits so that this population can more freely refuse unsafe work, report issues, change employers, and access timely medical and social care (Caxaj & Cohen, 2021a; Caxaj et. al, 2020). Although the federal government recently launched the Open Work Permit for Vulnerable Workers (OWP-V) and job bank as mechanisms for workers to report and leave situations of workplace abuse, this initiative is limited insofar as it places the burden of proof on the worker. Moreover, there is no consideration of workers' need for housing throughout the OWP-V process, nor is there a guarantee of alternate employment in cases where abuse is proved. Ultimately, a clearer path for permanent residence, in combination with greater labour protection and opportunity for migrant agricultural workers to participate in labour unions and collective bargaining, are necessary to uphold the health and human rights standards to which they are entitled.

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