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MIGRATION AND HEALTH: IMPLICATIONS FOR DEVELOPMENT

A CASE STUDY OF MEXICAN AND JAMAICAN MIGRANTS IN CANADA'S SEASONAL AGRICULTURAL WORKERS PROGRAM

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Executive Summary

This paper explores the nexus of health and migration for development, focusing on the experience of Mexican and Jamaican migrant workers in Canada's Seasonal Agricultural Workers Program (SAWP), a managed migration program that employs Mexican and Caribbean farm workers throughout Canada. It argues that the SAWP has mixed health and development outcomes for migrants: while generating remittances, which help reduce poverty and address health concerns, the SAWP does not do enough to protect and ensure the long-term health of migrants who work in a precarious industry and live across national borders. The paper presents research-based data on health outcomes of SAWP participants in Canada, Mexico and Jamaica; highlights issues of workers' healthcare access in the three countries; discusses implications for long-term health and development; assesses current health initiatives for migrants and makes policy suggestions to benefit stakeholders. Data is based on ethnographic research, including participant observation and qualitative interviews, conducted since 2005 with migrant workers, employers, government officials and health professionals in southwestern Ontario, Canada, central Mexico and southern Jamaica.¹

Migration, Health and Development: Overarching Issues

As international migration increases across the world, concerns are raised about the health of migrants and their access to healthcare services in their countries of origin and destination. The positive linkages between accessible healthcare and development are numerous, including more equitable health indicators between different segments of society, and populations that can lead longer, more productive, higher quality lives. Human rights and moral imperatives also support the need for the insurance of health protections and equitable and accessible healthcare. Amidst a global economic downturn, such rights may be particularly at risk for such mobile, vulnerable groups as migrant workers. Despite these important considerations, official discussions regarding migration and development often neglect or downplay issues of health.

The intersections of migration, health and development are as complex as the diverse contexts in which migration takes place; they also vary for different kinds of migrants and geographic milieus. For example, analyses of these issues often highlight the ‘brain drain’ of health professionals, leaving migrant-sending countries with fewer healthcare personnel.² However important this may be, the discussion here will focus specifically on the issues most apparent in the migration of temporary (or circular) ‘low-skilled’ economic migrants, as is the case in the SAWP, and in particular, the health effects of such movements for migrants.

The health outcomes of migration have implications both for development and for human rights. The right to the highest attainable standard of health, or the right to health, has long been recognized in international law, but questions arise regarding who is responsible for providing such entitlements. In this respect, human rights are somewhat paradoxical for international migrants. While rights are recognized as universal (applicable to everyone everywhere), they are also primarily premised on the relationship between individuals and the obligations of the state to respect, protect and fulfill the rights of citizens.³ What then are the implications for people who live and work in nations in which they are not citizens?

The health of transnational migrants is affected by a variety of factors, including previous health conditions, the circumstances of the migration (e.g., irregular or legal, permanent or temporary), types of housing and working conditions, access to healthcare and other social services, language barriers, contact with family and community, and a variety of other social determinants of health.⁴ Given that migrants, particularly those recognized as ‘low-skilled,’ often face precarious and dangerous working conditions, separation from family, poor living and working conditions, and low wages, etc., it is not surprising that they are vulnerable to a number of health risks and often face inadequate access to healthcare. The World Health Organization (WHO) notes that occupational accident rates are roughly double for immigrant workers in Europe as opposed to native workers, and that this is likely similar elsewhere in the world.⁵ Yet, the often serious and long-lasting health concerns of migrants, and the responsibilities of both sending and receiving states to protect the health of people who live and work across national borders, have been largely neglected within policy and academic debates surrounding international migration. This gap led the WHO to conclude that there is a “lack of data, which makes it impossible to present a coherent picture of the inter-linkages between migration, health and human rights.”⁶

This neglect may in part be due to the high costs of providing comprehensive healthcare services, and a lack of recognition of the rights of migrants living and working in places in which they are

not citizens. It is also true that not all countries provide universal healthcare even for their own citizens. The prevailing belief that the benefits of migration outweigh any costs obscures the need for a critical examination of these issues. The health outcomes of migration often become a silent trade-off amidst the compelling economic forces and related development impacts, which propel and sustain migration flows both for participating states as well as for individual migrants, their families and communities. This paper purports that a fuller understanding of the issues can be gained by recognizing the existence of complex and sometimes contradictory inter-linkages between health, migration and development.

Overview of the Seasonal Agricultural Workers Program

The Seasonal Agricultural Workers Program (SAWP) is Canada's principal guest worker program for agriculture. Labelled as Canada's "flagship temporary migration program,"⁷ academic, policy and political forums have viewed it as a model initiative, lauded for its ability to meet the flexible labour needs of Canadian farmers through the orderly movement of workers in times of peak demand, and their immediate return when their labour is no longer needed. As Manolo Abella has noted, the expansion of managed temporary migration programs such as the SAWP has been widely advocated by international and intergovernmental organizations, as a means to meet the economic needs of both migrant sending and receiving regions, while alleviating the pressures of permanent or irregular migration and immigration.⁸

Beginning in 1966 when 264 Jamaican workers came to Ontario, the SAWP later expanded to include workers from Barbados, Trinidad and Tobago, and the Organization for Eastern Caribbean States. Mexico joined in 1974 and has since become the primary country participating in the program (with more than 13,000 spots in 2006), followed by Jamaica (with roughly 6,000 spots in 2006). More than 20,000 SAWP workers are now employed annually across Canada, with the highest concentrations in Ontario (with nearly 18,000 approved vacancies in 2008) and Quebec, followed by British Columbia and Alberta. In Ontario, the principal agricultural sectors employing workers are vegetables (with 4,553 approved vacancies in 2008), followed by greenhouse (3,888), fruit (3,423), apples (1,739), tobacco (1,397) and nurseries (1,280). Other participating sectors include (in order of frequency): ginseng, flowers, canning/food processing, bees and sod.⁹ The vast majority (approximately 97 per cent) of workers are men, although women's participation has been growing since their introduction to the program in 1989. Workers spend between six weeks and eight months in Canada each year. Regardless of the amount of years spent on the program, workers are normally ineligible to settle in Canada or stay beyond their contracts.

The program is mandated by an intergovernmental administrative arrangement known as a Memorandum of Understanding (MOU), and operates based on bilateral agreements, negotiated annually between the countries involved. The involvement of sending governments with the program, including recruitment, selection and facilitation of movement of participants, as well as mediating any issues that may arise in Canada, helps to prevent exploitative practices often found in situations of irregular migration, while also ensuring that Canadian employers receive workers who have been closely screened. Administration of the program in Canada is undertaken by private, employer-run organizations.

The SAWP provides economic benefits to workers and employers as well as the Canadian society in which migrants live, spend money and pay taxes, employment insurance and pension

premiums. The success of the SAWP has served as a basis for similar temporary foreign worker programs, which have expanded rapidly in Canada over the past decade, in agriculture as well as in other industries.

Participants are guaranteed many of the same rights and benefits as Canadians, including minimum or prevailing wage. The SAWP agreements include several relevant clauses with respect to health-related issues, stipulating that employers are responsible for applying for health coverage according to provincial regulations, arranging for transportation for workers who require medical attention and ensuring that they have compensation for work-related injuries and disease. Employers must also provide workers with accommodation at no cost that is subject to inspection and government approval. There are further stipulations regarding normal hours of work and the provision of training and protection of workers using pesticides.

Critics of the SAWP, however, contend that Canada has been lacking in its protection and promotion of workers' rights. Given the difficulties in establishing existing human rights frameworks and of ensuring migrants' rights, as noted earlier, several international agreements have emerged relating specifically to the protection of migrants. Most notably, the 1990 UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families has been called the "cornerstone of the 'rights-based approach' to migration."¹⁰ Although Canada relies heavily on migrant workers, it has not ratified these agreements. Canada is not alone in its decision. Ratifiers of the Convention are primarily from migrant-sending regions, while migrant-receiving countries have generally not done so.

Furthermore, critics charge that by excluding agricultural workers from the protections considered standard in other industries, Canadian provinces have failed to implement or apply adequate legislation to protect the rights and health of these workers.¹¹ In Ontario, where the vast majority of SAWP participants have been employed, agricultural workers are excluded from various components of the Employment Standards Act. Farm workers in Ontario have also long been excluded from the Occupational Health and Safety Act; this exclusion ended only in 2006 following court challenges led by the United Food and Commercial Workers (UFCW) union. They are still denied the right to bargain collectively as part of a union (this matter has also been contested by the UFCW and other groups; the case is set to be heard by the Supreme Court later this year). Critics further point out that the program makes it difficult for workers to transfer freely between employers, while they can be fired and repatriated without access to a formal appeals process. With no security for future employment, these workers are vulnerable, which can make it difficult for them to claim their rights, access entitlements, or make complaints about abuse.

Major Health Issues of Migrant Farm Workers

Both the United States and Canada have long relied heavily on migrant farm workers from Latin American and the Caribbean for labour-intensive agriculture, which is among these countries' most dangerous industries. Literature reviews of farm worker health in the United States demonstrate that health and safety concerns are both more prevalent and occur with greater incidence than in other occupational groups.¹² Occupational exposures and conditions common in agriculture (pesticides, noise, sun, awkward work positions, use of machines, long hours) constitute significant areas of risk. Common health problems include: musculoskeletal disorders and injuries, cardiovascular disease, hypertension, premature death, certain cancers, hearing loss, der-

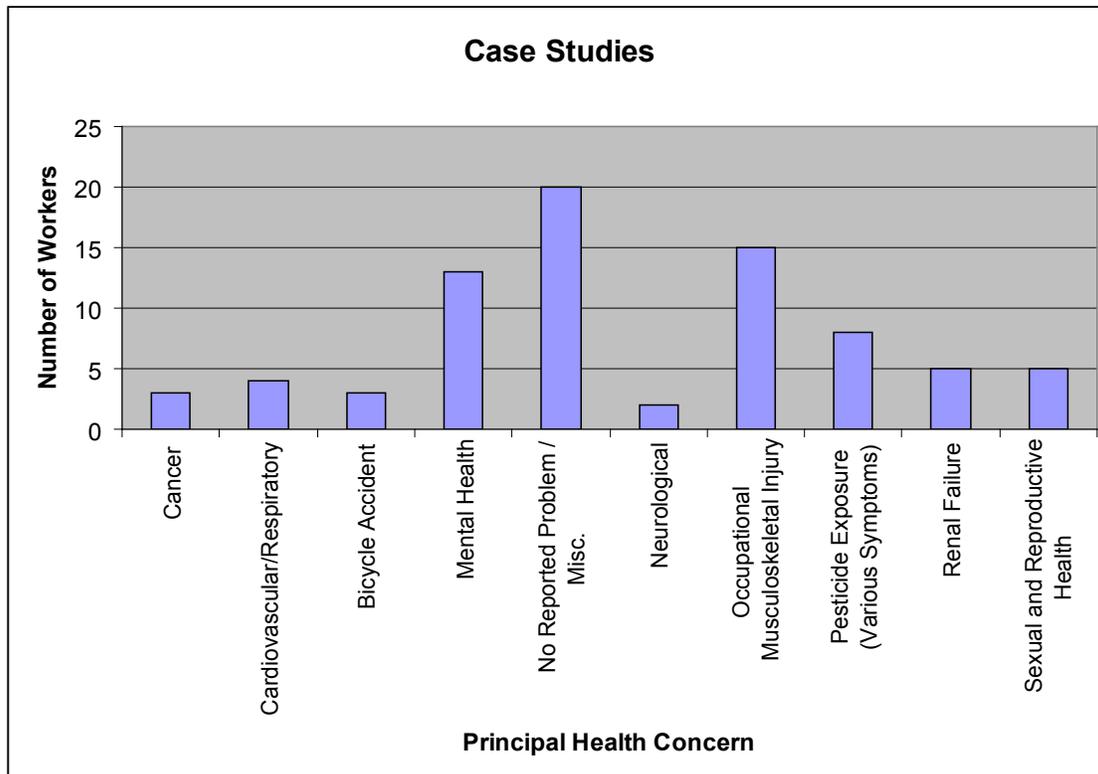
matological concerns, eye problems, infectious diseases (such as tuberculosis (TB) and various sexually transmitted infections), diabetes, respiratory and lung diseases, mental disorders (such as depression and anxiety), climate-caused illnesses, ulcers, bladder, kidney and liver disorders, and reproductive problems such as infertility, birth defects and miscarriages.

While most farm workers in the United States are irregular migrants and immigrants, migration through the SAWP allows for greater regulation concerning health. Most notably, applicants for the SAWP normally undergo a medical exam in their country of origin before they can be approved for entry to Canada. The exam, which is determined and monitored by Canada, but undertaken by designated medical practitioners in the workers' countries of origin, serves the dual purpose of ensuring that migrants do not arrive with pre-existing health concerns, which will burden the Canadian system or cause problems for Canadian public health, and also that they will be physically and mentally able to handle demanding working conditions. This exam may contribute to mitigating the incidence of pre-existing health concerns arising in the Canadian context, particularly regarding communicable diseases such as active TB. In the 2009 season, when concerns were raised about the possibility of Mexican farm workers arriving in Canada with the H1N1 virus, additional screens were put in place at the airport. This health screening contributes to ensuring a healthier workforce arriving in Canada, but it does little to ensure that workers stay healthy until and after they return to their countries of origin.

Although health has been less examined than other issues in the SAWP, such as workers' rights and conditions, social relations and development impacts, combined evidence from many authors investigating the program suggests disturbing and consistent patterns in agricultural workplaces. Gustavo Verduzco and María Isabel Lozano found that 16.8 per cent of the Mexican workers in their survey had a work-related accident on one or more occasion (mainly resulting in musculo-skeletal injuries), while 31 per cent became ill during the working season in Canada.¹³ Principal concerns identified included: "respiratory tract, followed in importance by gastritis, ulcers, and other stomach diseases, skin diseases, allergies, back problems and/or muscular pains."¹⁴ Roy Russell's survey of Jamaican workers revealed an 11 per cent injury and 13 per cent illness seasonal prevalence among participants, while "approximately 32 per cent of workers reported that they 'suffer long term illnesses as a result of injuries/illness' received while working on Canadian farms."¹⁵ Kerry Preibisch concluded that: "farm workers face significant work-related health and safety risks, including heat stress, exposure to pesticides, and workplace injuries."¹⁶ Research with Mexican workers in British Columbia found that "nearly half of respondents expressed that they feel their employer never or almost never ensured their health and safety."¹⁷ Preliminary results from ongoing quantitative research focusing on health among migrant farm workers in Ontario suggest similar findings, and highlight migrants' vulnerability to communicable disease.¹⁸

Identifying major health issues among migrant farm workers in Canada was a primary focus of recent research.¹⁹ Similar trends between the various research methods employed (interviews, participant observation and clinical observations) identified that many of the SAWP participants' common health issues are similar to those occurring for migrant farm workers in the United States. This research included the additional dimension of tracking select workers, many of whom experienced long-term illnesses and injuries, between Canada, Mexico and Jamaica. The principal health issues among the 78 case studies selected for in-depth study are summarized in Figure 1.²⁰

Figure 1: Case Studies By Primary Health Concern



With respect to occupational health, exposure to risks such as agrochemicals and climatic extremes is exacerbated by insufficient and inconsistent access to training, personal protective equipment and sanitation facilities; and by poor communication with employers, including a prevailing reluctance to make complaints or request changes in circumstances. The majority of workers surveyed in the research (79 per cent) said that they experienced at least one acute symptom that they believe to be associated with pesticide exposure during their work in Canada. The most common symptoms related to skin (rashes, irritations, prickling sensation) and eyes (burning, irritation, redness, blurriness). Respiratory and gastrointestinal symptoms were also prevalent.

Long hours of work with few breaks, combined with continual bending or lifting in awkward positions, contribute to numerous incidents of musculoskeletal disorders (MSDs), particularly involving back, neck, shoulder, knee and leg pain. Acute injuries, often resulting from falling off of farm vehicles or platforms, are also common. In total, including the case studies and those identified in participant observation, this research recorded 79 incidents of musculoskeletal concerns, including 22 resulting from acute injuries. Work-related musculoskeletal problems also comprised 26 per cent of workers' visits to the Occupational Health Clinics for Ontario Workers (OHCOW) migrant worker clinics in 2008.

Mental and emotional health problems are prominent among migrants, who commonly suffer from such concerns as depression, anxiety and addictions. Principal sources of stress include: displacement and separation from their families and communities and a lack of social support in Canada; lack of control over working and living environments; and workplace and household

tension with both supervisors and among co-workers, who are placed in positions of competition with each other.

Sexual and reproductive health are also major areas of concern, as many workers engage in sexual relationships without adequate access to protective measures while separated from families and communities. Sexually transmitted infections, including Chlamydia, gonorrhoea, HIV and HPV, have been found among SAWP migrants. Women migrants sometimes experience unwanted pregnancies and find it difficult to negotiate time off to access prenatal care; some miscarry or seek abortions.

Many workers feel that the housing guidelines, enforced by pre-season inspections, do not go far enough nor are the dwellings inspected throughout the season to ensure maintenance. Workers often described overcrowded conditions, insufficient cooking and food storage space, a lack of privacy, no telephones and excessively hot or cold temperatures. These conditions contribute to a number of concerns, including inconsistent and insufficient sleep patterns, mental health issues, and poor nutritional and hygiene practices. In addition, most migrants use bicycles, which are normally poorly maintained and lacking safety equipment, as a principal means of transportation. Major injuries and fatalities have occurred as a result of bicycle-related incidents.

In the absence of comparable statistics, it is impossible to contrast migrant workers' injury rates to those of resident Canadian agricultural workers. Yet the indications provided from this combined data (as well as from the international literature) suggest that the experience of illness and injury among migrant workers is likely disproportionately high compared to other working Canadians, who, because of their position as citizens and members of the resident society, with typically higher education and language similarity with the local population, likely have better access to information and protective equipment. Most importantly, Canadian permanent residents and citizens also have the relative freedom to leave workplaces deemed unsafe or unhealthy in search of other employment, while SAWP participants are meant to stay with the assigned employer. Indeed, the fact that many Canadian employees do leave when the work gets too difficult was one of the main rationales for founding the SAWP in the first place.

Access to Healthcare in Canada

SAWP workers have benefited from health coverage in Canada, receiving assessments, treatments and, in some cases, even surgeries. However, many workers find it difficult to gain access to their legal entitlements. Most employers mediate access to the workers' health cards, their work hours, transportation, and their ability to take time off work; in some cases, the employers also translate for workers who do not speak English. Yet the employers also control workers' dismissals and the evaluations which influence future involvement in the program. These power dynamics make their mediation of workers' healthcare access problematic for workers, even in cases where employers may have the best intentions or go out of their way to facilitate care.

In this context, the common barriers that workers experience to access healthcare include: a lack of access to independent transportation; long work hours; unwillingness to inform employers when sick or injured for fear of losing current or future employment; lack of knowledge about various services; and being repatriated when sick or injured. Some workers do not receive their health cards, receive them late into the season or they are received but held by employers.

Additional barriers exist in the relationship between healthcare providers and workers. Language, health literacy and cultural differences among workers, combined with a lack of time and specialized training among the practitioners treating them, amount to instances where workers felt neglected, misunderstood or experienced a lack of trust. Particular challenges were identified with regard to healthcare provision that required follow-up or extended care across regions or borders as well as access to specialized care, such as mental, sexual, prenatal, occupational, dental and ocular health services.

While the aforementioned issues were found consistently among both Jamaican and Mexican workers, most Mexican workers face the additional burden of being unable to communicate directly with either employers or healthcare providers, constituting a significant barrier to reporting concerns and negotiating healthcare access. The Mexican government has provided workers with a health translation sheet, which is a welcome and useful resource. This research found, however, that workers generally did not make use of this sheet during medical consultations. At the same time, physicians who had not received these sheets indicated that they would appreciate support for translation.

Access to Healthcare in Mexico and Jamaica

Systems of transnational migration often fail to sufficiently provide for the long-term health needs of migrants. The Global Commission on International Migration has documented the concern that “less than 25 per cent of international migrants work in countries with bilateral or multilateral social security agreements, and such agreements do not necessarily provide the same portability for healthcare benefits.”²¹ Likewise, recent research conducted on returning Mexican migrants from the United States concluded that they are “uniquely disadvantaged for accessing health insurance.”²²

The SAWP presents similar challenges. Although participants receive health coverage in Canada, these benefits are not long-term or portable. Sick or injured workers normally have nowhere to reside in Canada outside of their employers’ residences and their health coverage expires after each year’s contract completion. They are, therefore, normally repatriated if they become too sick or injured to continue working.

If a worker’s illness or injury is deemed to be work-related, they may be eligible for coverage under workers’ compensation; these benefits can be received and extended after workers return home. Not all work-related illnesses and injuries are recognized or reported as such, however, and workers face barriers to filing for claims similar to those they encounter to access healthcare. For example, many healthcare providers are not aware of migrant workers’ entitlements to compensation and migrants are often hesitant to report incidents. Repatriations that occur prior to workers’ conditions being fully investigated or resolved can lead to further difficulties and complications in assessing workers’ conditions and accessing their entitlements.

Workers who develop conditions that are not work-related in Canada are eligible for some limited support under supplemental plans to which they contribute in Canada, which differ by country of origin. Mexicans pay into a private insurance plan, while Jamaican workers are covered under a National Insurance Scheme administered by their government. These plans offer only minimal and temporary coverage for workers once they return to Mexico or Jamaica; they might better

be viewed as travel insurance than as long-term health coverage. Thus, many migrants who have paid taxes and contributed to healthcare plans in their country of employment are left without long-term support to access healthcare in their countries of origin. Here, as is the case in many countries, there are multi-tiered, fragmented systems of healthcare.

In Jamaica, health services have been declared to be a priority of the government, allowing for the development of a relatively strong public health system. Major cuts in health spending in the wake of financial crises and debt servicing over the last few decades, however, have left the island with fewer hospitals and healthcare personnel (exacerbated by some healthcare professionals migrating overseas for better income). There is now a co-existing private and public health system; the latter emphasizes primary care. Patients are subject to user-fees and funding for more costly procedures is insufficient. Long waiting lists at public facilities mean patients who cannot afford care often go without. Domestic workers in some sectors contribute to and receive coverage under group health insurance plans, but these are not provided to former SAWP participants.

Mexico's healthcare is also a mix of public and private systems. The private system operates on free market principles and is available to those who can afford it. Employed Mexicans and their dependents are eligible for coverage under the Instituto Mexicano del Seguro Social (IMSS), the Mexican Department of Social Security, funded by workers, employers and government.²³ Like their Jamaican counterparts, Mexican employees contracted under the SAWP are not covered by these systems. Recently there have been important efforts to expand healthcare services to Mexico's uninsured populations, particularly to pregnant women and babies. However, the efficiency and quality of care in the public system is typically much lower than for those who are insured, with fewer resources and personnel, for which patients normally pay part of the expenses. The result is that those with resources or insurance plans can receive relatively prompt and modern treatments, while the poor and uninsured are left without timely access to many services.

In both countries, health insurance plans to which domestic workers and their employers contribute are not applicable to SAWP participants, who earn income and contribute to taxes and benefit plans abroad. Some residents may be able to purchase high quality private insurance plans or treatment out-of-pocket, but these are typically unaffordable to migrants. Even lower-priced, less comprehensive plans may be viewed as unaffordable by migrants, who, with no sense of job security, try to save as much income as possible, and who may not consider the need for domestic insurance when they spend much of their time abroad. While basic services such as vaccinations and family planning may be attainable at local public health centres, costly treatments, such as chemotherapy, physiotherapy, renal replacement therapy, surgeries or medications, are often unaffordable. Just paying for the transportation to seek such services can pose a significant barrier to rural residents who lack the resources to travel to urban medical centres.

Implications of Migration for Health and Development

Migration has been deemed the “new development mantra”²⁴ for good reason. According to the most recent World Bank figures, international remittances totaled \$328 billion for developing countries in 2008.²⁵ Remittances comprise an increasingly essential form of income for poorer countries (second as a source of foreign income to foreign direct investment).²⁶ Both Mexico (overall) and Jamaica (per capita/GDP) are major beneficiaries.²⁷

Remittances provide funding for health-related initiatives and treatments as well as income which supports the promotion of related social determinants of health (nutritious food, education, shelter, poverty reduction, etc.). In addition, returning migrants may contribute to their communities through enhanced entrepreneurship and the transfer and application of newly acquired skills and knowledge, which may in turn provide further economic multiplier effects. Health and safety awareness training provided to migrants, either in pre-departure information sessions or while abroad, may contribute to furthering community awareness of such issues and to improving health practices. Migrants, both as individuals and through associations, may also invest in community infrastructure, such as clinics, schools, parks and churches.²⁸

This research found that SAWP remittances contribute to migrants improving the standard of living for their families, which has health-related outcomes. Unlike irregular migrants, who must sometimes pay thousands of dollars to arrange trips, the costs of entering the SAWP are comparably minimal, thus allowing poorer groups to participate. These migrants, particularly those who have migrated over multiple seasons, more often are able to afford to build homes with adequate structures, plumbing, phone lines and vehicles; to feed, clothe and educate their children; and to pay for medical treatments when health issues arise. One Mexican mother, for example, repeatedly migrated to Canada to pay for her son's cancer treatments. Other migrants support elderly parents or disabled family members. Repeat migrants sometimes invest in land, animals or small businesses, but in most cases such ventures are used to supplement rather than to replace SAWP income. Noting similar findings in the Mexican context, Leigh Binford concludes that the SAWP is likely better conceived of as a poverty alleviation program than as a development program.²⁹ Still, alleviating poverty is a significant benefit for those who participate, and undoubtedly contributes to positive health-related outcomes for migrants and their families.

Some of the less tangible and recognized lasting effects of migration include the impacts on migrants' family lives. Many migrants report returning to strained or broken marriages, distant relationships with their children, physical and emotional scars. During long absences, both spouses may develop other relationships, which can lead to marital strain and also to unwanted pregnancies and the spread of sexually transmitted infections.

Children, who spend much of their youth separated from either or both parents, describe a sense of resentment and loss, while migrants lament how their children develop bad habits (such as drug or alcohol consumption, poor school attendance or engagement in petty crime) in their absence. Many migrants and their families report experiencing heightened depression and anxiety in times of separation; others develop dependencies on drugs or alcohol, which may endure years after the migration has taken place. Some migrants have recounted tales of their children dying while they worked in Canada, speculating that their absence (and inability to care for them) was partly to blame. While similar issues may be experienced among orphans, children of separated parents, etc., this form of continual, widespread migration engenders a unique and profound sense of rupture, one that is not only experienced at the individual level, but also at those of the family, community and society.

Although workers are extensively screened for health issues before leaving for Canada, there is little monitoring prior to or upon their return to their countries of origin. Given the SAWP health screening and anticipated rigors of work, those who are sick or injured often simply fail to re-apply to the program or are denied re-entry. The result is that workers' long-term health is not

systematically monitored, and the percentage of those who return home with or later develop injuries and illnesses is difficult to quantify.

This research uncovered numerous cases of former migrants who did not return to Canada due to long-term injuries or illness. Some of these long-term issues included addictions and mental health concerns, musculoskeletal problems, sexually transmitted infections and, in extreme cases, conditions such as paralysis, motor impairment, cancer, liver, heart or kidney disease. Between Mexico and Jamaica, seven families of workers who had died either in Canada or shortly after returning home, were interviewed. A common theme was a lack of financial or emotional support for those left behind.

When workers return home injured or lose their lives, their families also suffer the consequences. In the absence of adequate long-term social protections, many workers and their families have no way to replace or supplement their income, and therefore to support themselves. In such cases the effects on family dynamics and the sense of self-worth and dignity among workers can be profound.

Health-Related Initiatives

The long-standing nature of the SAWP has led to some innovations and initiatives in health education and care for workers, though often in an inconsistent and ad hoc manner. In both Mexico and Jamaica, workers receive some basic training on health-related issues before departure, the main topic of which is sexual health (with a focus on HIV prevention). Pamphlets on health issues prepared for Mexican migrants bound for the United States have been adapted and provided for SAWP participants, dealing with issues such as tobacco and alcohol use, basic hygiene and condom use. Some workers have also received tips on bicycle safety. Occupational health and safety issues, however, are notably lacking in the workers' training.

In Canada, civil society and labour groups have become involved with education and support efforts regarding migrant health. A bilingual health and safety manual is distributed to workers primarily out of support centres run by the United Food and Commercial Workers (UFCW) union. Various advocacy and support groups have provided workshops on health and safety. Volunteers have helped to support workers' transportation and in language interpretation to aid them in seeking medical attention. Relationships built in Canada often extend after workers return to countries of origin. Several organizations, including the UFCW, Justicia for Migrant Workers, and the Industrial Accident Victims Group of Ontario, have sought to provide assistance to workers after they have been repatriated. For example, they have assisted them in applying for workers' compensation and other benefits.

OHCOW, with funding from the Workplace Safety and Insurance Board of Ontario, has been holding regular specialized occupational health clinics for migrant workers in rural Ontario since 2007. In the 2009 season, bi-weekly clinics have been held in Simcoe, with satellite clinics occasionally taking place elsewhere. The clinics are offered in accessible locations and times, typically near the grocery stores frequented by workers on Friday nights. Medical services are provided by occupational health specialists aided by interpreters and targeted information pamphlets. No health cards are required. If a worker has a workplace injury or illness, volunteers and staff are

on hand to help fill out a workers' compensation application. When needed, communication with workers may continue even when they are repatriated to their countries of origin.

The project also provides workshops and safety interventions to migrant workers. In response to a high number of patients reporting ocular symptoms, workshops on eye safety, including the free provision of safety glasses, were provided at clinics, community events and on farms in the 2009 season. Despite the limited nature of the project, and challenges such as workers' ongoing reluctance to file for workers' compensation, to report an injury or to request time off work for follow-up appointments, the clinics have provided a measure of accessible care to those who have attended them. This is a model that could well be adapted for other common health concerns, such as mental and sexual health.

Conclusion

Many migrants are able to improve their standards of living through participation in the SAWP. Remittances have often provided the basis for health-related and supporting expenditures, including shelter, food, education and healthcare. Any health-related development or poverty alleviation impacts must be balanced, however, against the negative consequences of migration. From both a development and human rights perspective, migrants require better support to ensure that they remain healthy while working abroad, and upon their return to their countries of origin. Although some initiatives have begun to provide basic education and health services to migrants, these efforts are only a beginning. They require expansion, sustainable funding and cross-border collaboration. For those migrants who suffer long-term injuries or illnesses, comprehensive portable security benefits could help to ensure that they and their families are better supported, so that the positive changes brought about by migration are not undermined by any negative effects.

Policy Recommendations and Benefits to Stakeholders

The SAWP provides immense economic benefits to workers, employers and participating governments. It is in the interests of all stakeholders to ensure the smooth functioning of the program, and all could benefit from improved migrant health. Migrants and their families will enjoy better health outcomes and access to sustainable care when problems arise. Employers will gain from healthier and happier workers through increased productivity and worker satisfaction. The governments and program officials involved will benefit from administering a program which ensures workers' rights and safety, and is in-line with international human rights, outcomes which reflect positively among all parties. Sending countries can only gain from workers remaining healthy, productive, contributing members of their societies. A number of changes can help to ensure that these outcomes take place.

In Canada

- Canada should reconsider ratification of the UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. In its absence, Canada should adopt more comprehensive migrant rights guarantees in accordance with international standards and guidelines.

- Agricultural workers in every province should receive the same standard rights as workers in other industries.
- All migrants should receive health cards immediately upon arriving.
- A bilingual, independent, toll-free ‘telehealth’ line should be made available to migrants to provide advice on health-related issues and services. The line could also offer free interpretation services for workers seeking medical attention.
- Health outreach services, such as the OHCOW model, a migrant health bus, and/or other specialized clinics, should be implemented and/or expanded in all high density areas where migrants are employed, offering targeted services with interpreters at hours and locations accessible to migrant workers.
- Years of separation create high tolls on both migrants and their families. Migrant farm workers should have the opportunity to immigrate to Canada if they wish (like other classes of temporary foreign workers), and for family reunification and/or visits when needed.
- Migrants’ vulnerability to health problems (and reluctance to access care or report problems) would be greatly reduced if they did not fear repatriation, or loss of future employment for becoming ill, burdening or disagreeing with employers. To provide workers with a greater sense of job security and empowerment, several changes could take place. Workers should be eligible to transfer freely between employers through open or industry-specific work permits. Migrants’ future employment should be based on demonstrated practical experience in Canada, not employers’ requests. Employers should have to clearly demonstrate just cause for terminating a worker’s employment, and this decision should be open to a formal, independent, appeals process.
- More education should be provided to employers and healthcare providers servicing migrant workers regarding their needs, vulnerabilities, rights and entitlements. In the absence of more comprehensive interpretation support, at minimum Spanish-English medical translation sheets and a list of useful contacts and support services should be given to all healthcare providers who regularly see migrant workers.
- Complaint-driven models (i.e. for concerns with housing or working conditions) are ineffective for migrants who are unaware of systems, face communication barriers or fear retribution for issuing complaints. They should be complemented with random inspections to ensure ongoing healthy and safe living and working conditions. This would benefit not only migrants, but all farm workers.
- Housing guidelines should be revised with workers’ input to address their concerns (e.g. maximum temperatures, increased privacy, mandatory telephones).
- Workers should receive medical screening prior to returning to countries of origin, especially when premature repatriations are taking place. If they have a health concern, they should receive support to continue receiving treatment in Canada until it has been addressed. Investigations regarding workplace injuries or illnesses should be fully resolved before workers are repatriated.

In Migrants' Countries of Origin

- Long-term, portable social security benefits, including long-term health insurance and benefits, should replace the current temporary health insurance models.
- Migrants and their families should receive ongoing support and education regarding common issues such as sexual and mental health.
- Occupational health and safety training, and detailed information about workers' rights and entitlements, including information about how to access healthcare and to advocate for one's rights, should be incorporated into all workers' pre-departure information sessions. Basic information should be standardized across countries of origin, although this should be adapted for different groups' cultural and linguistic needs.
- Support programs such as employment retraining and employment insurance should be put in place to assist workers who are no longer able to migrate. Support for the families of workers who died or suffered from serious health problems while on the program or shortly after returning should also be offered.

Endnotes

¹ The purpose of the research (McLaughlin 2009) was to explore major health issues occurring among migrants to Canada, and to evaluate their access to healthcare in Canada, Mexico and Jamaica. After establishing contacts and building relationships of trust with migrant workers in Canada in 2005-6, two winter seasons (2006 and 2007) were spent residing with workers and their families in Mexico and Jamaica. Summers in 2006-2008 were spent primarily in the Niagara region of Ontario. A principal method of research was participant observation, part of which included volunteer work with several migrant worker support organizations, including running health-based workshops for workers, assisting them with accessing healthcare, and developing initiatives to address issues uncovered in the research. The author helped to facilitate migrant worker health clinics and education initiatives with the Occupational Health Clinics for Ontario Workers (OHCOW) migrant worker project, as a volunteer and then coordinator. From these participant observation and volunteer activities with over 500 workers, a subset of 78 case studies of workers was identified for further in-depth interviews, most of whom had noted health concerns. In addition, research was conducted with employers and supervisors (n=10), government and program officials (n=22), healthcare providers (n=24), and members of migrant worker organizations and communities (n=25) across the three countries.

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²⁰ The case studies were derived from qualitative methods, were not based on a representative sample, and are thus not meant to indicate representativeness of the issues identified. Only principal health concern is reflected. In some cases, multiple concerns applied (e.g. pesticide exposure and renal failure). Occupational Musculoskeletal Injury includes also musculoskeletal disorders.

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