ONTARIO BRANCH NEWS

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SUMMER 2007

MIGRANT FARM WORKERS

By Tetyana Slyepchenko B.A.Sc. with Susan Harding-Cruz, DEH, B.A.A., CPHI (C) and Dan Nagel B. Sc., CPHI (C)

Under Canada's Caribbean and Mexican Seasonal Agricultural Worker's Program (SAWP), thousands of workers from different countries in the Caribbean and Mexico are employed in agriculture, every year. SAWP is a federally authorized guest worker program that attempts to fill labour shortages in the Canadian agricultural business. The Foreign Agricultural Resource Management Services (FARMS) in Ontario administers the program.

Seasonal workers from Mexico and the Caribbean have been coming to Ontario for decades to help local farmers gather the harvest. SAWP or the “offshore program" regulates the recruitment of foreign farm labour for Ontario's harvest season. It was established by the Canadian and Jamaican governments through a Memorandum of Understanding (MOU) in 1966. The program then expanded to include Mexico, Trinidad & Tobago, Barbados, and the Organization of the Eastern Caribbean States.

Migrant workers are usually recruited to work as fruit, vegetable, and tobacco pickers or in greenhouses, nurseries, and canning factories. In 2002, over 20,000 foreign workers were employed in Canadian agriculture. Ontario receives over 80% of the migrant farm workers who come to Canada each year. Although the program is seasonal from May to October, many of the workers spend up to eight months in Canada.

In general, migrant workers who participate in SAWP are from rural regions, have little formal education and are small-time farmers in their home countries. To find gainful employment, they migrate temporarily to Canada for decent wages in order to support their families. Drawbacks of the program in the past included substandard working and housing conditions along with forced uncompensated overtime. The workers had no recourse as their families back home relied on the extra income. As a result, the workers did not act out of fear of exclusion from the program or deportation back to their home country.

Things have improved for the migrant farm worker.

Continued on page 5 ...

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Submissions Criteria:

- All topics must be relevant to the Public Health Inspection Field
- Articles must be submitted either on computer disk or by e-mail in MS Word (written articles will not be accepted).
- Articles submitted should be approximately 150 words (feature articles a maximum of 500 words).
- Feature articles will be determined by the OBN editorial team.
- Graphics or pictures included with the submission must be a resolution of 150—300 dpi.
- Articles must be submitted by the deadlines outlined below

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Message from the Editor

Except for the occasional update on public health issues in the media, I have begun to wean myself off of the news. It may be irresponsible, as a responsible adult member of the community to not be well informed, but it is a matter of self preservation. At each glimpse of the state of the world, I marvel at our abilities to harm one another. Human beings seem to be upping the ante in that category.

Firmly planted at the opposite end of the spectrum are hospitals. Their whole reason for being can remind a person that human beings have a large capacity for caring, especially for the sick. We do not leave the wounded by the side of the road to fend for themselves (well, for the most part, see above) but attempt to nurse them back to health.

During a recent rabies vaccine delivery to a hospital emergency and while waiting for the doctor, I began to take it all in. Various hospital staff were running around attending to the frail, sick and wounded with varying degrees of concern on their faces. (Okay, there's no need to split hairs , maybe some were feigning concern but at least the attempt was there.)

From your letters to the OBN and talks with fellow Public Health workers I can safely say that we are drawn to caring and helping just from a more pragmatic point of view firmly grounded in prevention. Seeing the Public Health cooler of vaccine, a number of the hospital staff began to ask about Public Health's role. As the conversation flowed, I was given another reminder, this time of our role on that really good end of the spectrum.

In this issue: ***Cathy Egan*** *sheds light on the epidemic strain of Clostridium difficile and how to capture those three little big letters CIC! Finish reading the fascinating piece on migrant workers on page 5 by* ***Slyepchenko*** *et al . Your past-prez* ***Mike Duncan*** *is talking to you. Find out what he has to say on page 10. You've been talking to us: Letters to the Editor can be found on the following page.*

Happy, glorious summer!

Heather Richards,

Editor OBN

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Letters to the Editor…

I very much like the on line version of Ontario Branch News. The issues are very timely (hazards of anti corrosive agents in steam to heat food, difficulty of treating an immigrant with active TB, the hazards of unpasteurized milk, scombroid fish poisoning) (Spring OBN 2007).

Some of the information is new but I also like being reminded of the public health stand on old issues that unfortunately flare up to become new issues. To PHIs these are "no brainers" but sometimes, for example, we need to hear about illnesses that pasteurization prevents.

Occasionally when correcting exams I see the same wrong answer repeated student after student. I then go back to my references to make sure I am not the one in error. It's the same thing here - the prominence of the media sometimes make us question our stance. Reminders are healthy.

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As usual, it's still a pleasure reading the OBN-Ontario Branch News -snugged with my coffee. I'm also getting some good reviews from my peers [this office]. The articles are "fresh and alive", lots of new information and learning material. Good Stuff !

Anyways...continue the good work.

Etrick B...

Etrick Blackburn
Thunder Bay District Health Unit

Thanks for writing!

To submit comments, questions and any other letter to the editor, please email communications@ciphi.on.ca or post mail to Heather Richards 235 Danforth Ave., 3rd Floor, Toronto, ON M4K 1N2

Migrant Workers (...continued from page 1)

In 2005, a Federal and Provincial inter-Ministerial and Local Agency Committee developed the document entitled, "Recommendations for the Provision of Seasonal Housing for Migrant Farm Workers". The document was designed to assist migrant farm workers and local authorities in their efforts to ensure the provision of safe, sanitary accommodations and facilities for the migrant farm workers.

In Ontario, seasonal housing must be inspected annually by the local health unit. For example, Public Health Inspectors/ Environmental Health Officers (PHIs/EHOs) in the City of Hamilton Health Unit complete the Migrant Farm Workers Accommodation Checklist during each inspection (see page 6). This checklist mirrors the recommendations contained within the 2005 Recommendations document.

Key areas that are addressed in the inspection and on the checklist include: location, construction, sleeping facilities, water supply, washrooms, food, garbage control, and maintenance.

The inspections are very detailed. For example, the building should be well away from animal shelters, in good repair and of sound construction. Other aspects of the inspection ensure that the floors, walls, and roof are built to standard and free from leaks, that there is an adequate source of light, proper ventilation, no obvious safety hazards, and that the room temperature is at least 20 degrees Celsius. Furthermore, the sleeping area must adequately accommodate workers without overcrowding and clean bedding is required. And finally, the water supply has to be tested for bacteriological safety as it must be potable.

The PHI/EHO also assesses the washrooms to ensure an adequate supply of sinks, tubs/showers, and toilets are provided. Access to laundry and drying facilities is also required.

The kitchen area is inspected to ensure food safety. Every food contact surface needs to be maintained, clean, sanitary and free of clutter.

Migrant farm workers can be at risk for injuries and illnesses associated with employment in agriculture. Working conditions, use of equipment, and exposure to chemicals can cause acute and chronic conditions, severe disabilities and even fatalities, if safety precautions are not followed.

Musculo-skeletal injuries are very common among the farm workers due to heavy lifting, incorrect body posture, and repetitive movements. Back and neck pain are the most common types of chronic pain workers experience. The most typical injuries are falls, cuts, and amputations.

Agricultural workers are constantly exposed to respiratory irritants (such as dust, pesticides, moulds, and pollen) and often have respiratory difficulties (allergies, bronchitis, asthma). People who work with crops could have skin problems caused by allergic reactions to chemicals and scratches. For example, 50% of tobacco workers experience green tobacco sickness at least once during the season.

In terms of infection control, tuberculosis and parasitic diseases are common due to improper sanitation on work sites and in residential places. Migrant workers in Canada can often live in overcrowded houses or deficient trailers that enhance the transmission of communicable diseases. An example of a recommended infection control measure is that cups should not be shared among the workers.

While there have been concerns with these various working and housing conditions, in Ontario, migrant farm workers are covered under the Ontario Health Insurance Program (OHIP) immediately on entry into the province.

The government of Ontario has also included agricultural workers under its provincial health-and-safety laws. As of June 2006, farm workers, including migrant workers, have the right to refuse unsafe work, to have the right to know about workplace hazards, and the right to forming a joint health-and-safety committee. This is all promising news and Public Health will continue to play a vital role in protecting the health of migrant farm workers.

MIGRANT FARM CHECKLIST

NAME OF FARM:
DATE:
ADDRESS:
TYPE OF WATER SUPPLY:
#OF WORKERS THIS YEAR: **WATER SAMPLE TAKEN:**
 # OF WORKERS LAST YEAR: **INSPECTOR:**

Satisfactory **Unsatisfactory**

GENERAL

Housing located 100 ft. or 30.48 m. away from animal shelters

CONSTRUCTION

Satisfactory **Unsatisfactory**

Floors tight fitting
Walls extend to 7ft. or 2.13 m above floor level
Roofs waterproofed
Lighting by either natural or artificial means
Ventilation by either natural or artificial means
Screens covering all openings to outside
Floors space (recommend 80 sq.ft. or 7.44m^2 person)
Temperature in rooms (min. 68°F or 20°C)
Safety Hazards (no inflammable materials in room
Combustion stove/heaters to be vented to outside
(Circle applicable type listed above)
Entrance to washroom not to be from food preparation area

SLEEPING FACILITIES/BUNKHOUSES

SEPARATE BUNK PER WORKER

Bunk 12” or 30.48 cm. off the floor
Bunks 18” or 45.7 cm. apart (except when length wise on wall)

Air space per bunk (recommended 300ft^3 or 9 m^3)
Mattress, pillow, linen clean
Constant supply of blankets, sheets (cleaned every week)
Locker or shelf space provided for each bunk

WATER SUPPLY

Readily available potable water
No common drinking vessels
Sanitary containers where applicable

Satisfactory **Unsatisfactory**

WASHROOMS

Hot and cold running water
One sink per seven (7) persons
One shower/tub per ten (10) persons
Privies located at least 25ft. or 7.62 m from nearest housing
Toilet tissue / and washing provisions
Clean and sanitary condition
One laundry tub per fifteen (15) persons
Or access to Laundromat - practiced where workers are taken to town weekly
Drying facilities for laundry

FOOD

Protective food storage
Storage temperatures not to exceed 41°F or 5°C
Utensil condition/cleaning/disinfecting
Kitchen free from equipment not used in kitchen area

GARBAGE CONTROL

Rodent proof containers in all buildings
Garbage disposal once per week minimum

MAINTENANCE

All buildings clean, sanitary, rodent proofed
Pest control
All buildings fire protected (incl. fire alarm & fire extinguisher)

Sewage System operating according to standards

REMARKS

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Adapted from City of Hamilton

Public Health Services, Health Protection Division

Those Three Little Letters: CIC Why and How to Get Them!

The Certificate of Infection Control and Epidemiology (CIC) is an internationally recognized level of excellence in infection control practice. To earn the designation of CIC, an individual must pass the certification examination administered by the Certification Board of Infection Control and Epidemiology Inc. (CBIC). This certification is valid for five years at which time a recertification is necessary. "CIC" is a legal designation that can only be used by those who have successfully passed the examination.

What is the purpose of the CIC?

- To provide standardized measurement of the current basic knowledge required for persons practicing infection control
- To encourage individual growth and promote professionalism

To formally recognize infection control professionals

Who is eligible to write the examination?

Eligibility depends on meeting both the education requirement and the practice requirement.

Practice Requirement

Candidates must have practiced infection control for a minimum of two years. Clinical practice of infection control occurs in various settings and its definition includes analysis and interpretation of infection control data, investigation and surveillance of suspected outbreaks of infection, education of individuals about infection risk, prevention and control, development and revision of infection control policies and procedures and consultation on infection risk assessment, prevention and control strategies.

Education Requirement

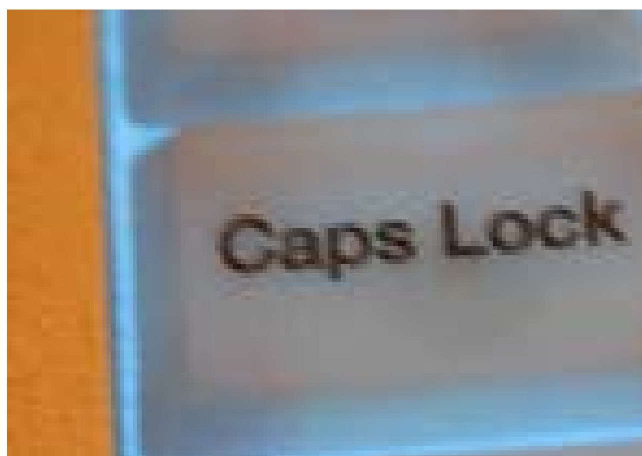
Candidates must have a current license or registration as a medical technologist or clinical laboratory scientist, physician or registered nurse, OR a minimum of a baccalaureate degree. An educational waiver may be applied for if this is not met but the individual meets the practice requirement.

How do I get more information and how do I apply to write the exam?

- Contact your Regional Infection Control Network for information about their CIC study groups, reference materials and study guides.
- Visit www.cbic.org to obtain a Candidate Handbook for details on the exam content and the reference material used to formulate the exam.
- Read two articles from the American Journal of Infection Control:

o "Infection Control Certification: A Global Priority", AJIC 2007; 35: 141-3.

o "Certification Board of Infection Control and Epidemiology white paper: The value of certification for infection control professionals", AJIC 2007; 35: 150-156.



The Epidemic Clostridium difficile Strain: B1/NAP1/027

By Cathy Egan B.A.Sc., MBA, CPHI (C), CIC

Clostridium difficile (C. difficile) has been garnering media attention as the cause of several challenging outbreaks in healthcare facilities in the past few years. A new epidemic strain has emerged that causes more frequent and more serious disease than previously known strains.

C. difficile is a gram positive anaerobic, spore-forming bacillus that can cause a range of disease from asymptomatic infection to death.

Since 2000, there has been an increase in *C. difficile* in many health care settings, and it is the most common cause of infectious diarrhoea among hospitalized patients.

C. difficile is not an antibiotic resistant organism, but rather an antibiotic-associated one.

The use of antibiotics alters the normal flora of the intestines and colon which allows

C. *difficile* to thrive and produce toxins that can cause an infection. After colonizing the gastrointestinal tract, *C. difficile* can cause a variety of manifestations ranging from asymptomatic colonization to severe diarrhoea, pseudo membranous colitis, toxic mega colon, intestinal perforation and death.

C. difficile associated disease (CDAD) can start during antibiotic treatment or even weeks after completion of a course of antibiotics.

Mild cases of *C. difficile* do not require treatment. Sometimes discontinuing use of the offending antibiotic is enough to resolve the symptoms. Although most patients with an initial episode of CDAD respond well to either metronidazole or vancomycin, 20% will develop recurrent episodes of CDAD that occur periodically over years, despite repeated antibiotic treatments.

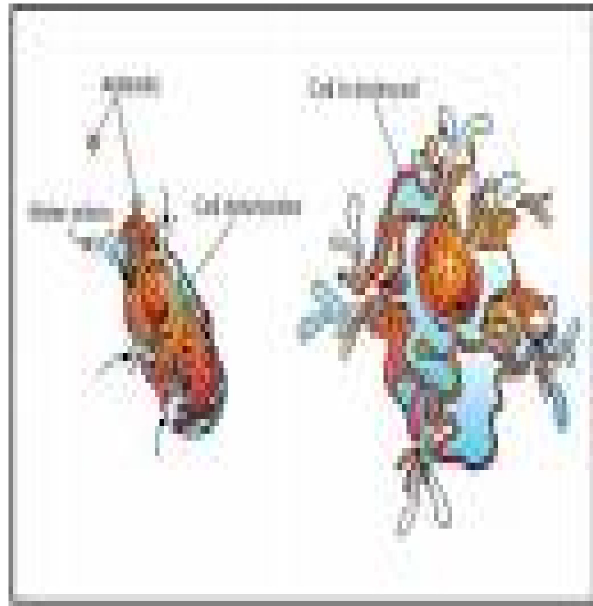
Healthy people are not usually affected by *C. difficile*. People who have underlying illnesses, conditions requiring prolonged use of antibiotics, and the elderly are at greater risk of infection. About 3% of healthy adults and 20-40% of hospitalized patients are colonized with *C. difficile*. Transmission occurs in healthcare facilities where exposure to antibiotics and environmental contamination by *C. difficile* spores are more common.

Historically low rates of severe disease and death (3% or less) may have led to an underestimation of the importance of CDAD as a health care-associated infection. Recent events and outbreaks have refocused attention on *C. difficile* infections and caused re-examination of assumptions about the virulence, known risk factors, and possible modes of transmission of this important infectious pathogen.

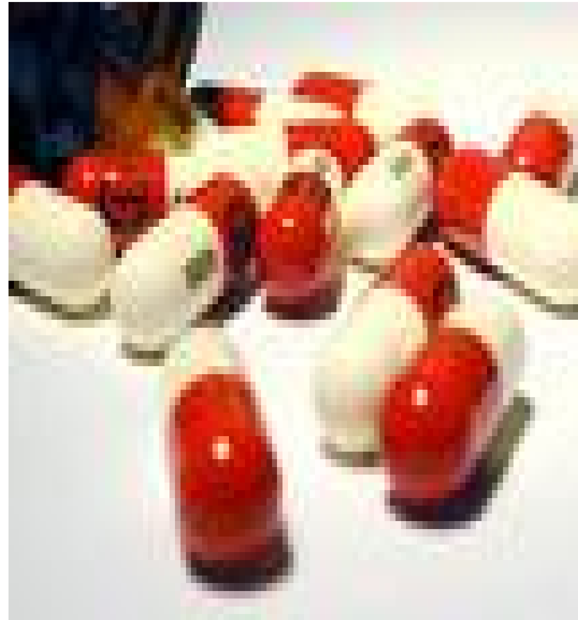
(Continued from previous page…)

The Epidemic Strain

This new epidemic strain is called B1/ NAP1/027. It acquires its name through combining the nomenclature of several strain typing methods. NAP1 (North American PFGE 1) is from the pulsed-field gel electrophoresis test, and B1 is from restriction-endonuclease analysis (REA). Polymerase chain reaction (PCR) tests name the strain as ribotype 027.



In 2002, hospitals in Quebec reported outbreaks of high numbers of cases of serious CDAD infections that were healthcare associated and had a high mortality rate. These outbreaks challenged practitioners to re-evaluate diagnosis, treatment, and infection control strategies in light of the changing profile of CDAD. An estimated 14,000 cases and 2000 deaths were reported in Quebec during this outbreak. *C. difficile* was the primary cause of mortality in 3.2% of the 2000 deaths. It was thought that possible causes for these outbreaks included the emergence of a hypervirulent strain of *C difficile*, suboptimal infection control practices, or a poor response to metronidazole, the standard treatment for CDAD.



The control of *C difficile* outbreaks requires multiple strategies, including disrupting routes of transmission (hand washing, patient isolation, enteric precautions), reducing the risk of exposure to *C difficile* spores through environmental cleaning and disposable medical equipment, reducing the pool of susceptible patients through antibiotic control policies that limit broad-spectrum antibiotic use; and reducing infectious cases through prompt diagnosis and effective treatment.

For more information on C. difficile, visit the Ministry of Health and Long-Term Care's website at www.health.gov.on.ca .

The Past President Asks…

Technology is used by organizations to enhance their efficiency in the collection, storage and analyzing of data. For example, in today's world it would be odd to see a shop keeper invoicing by hand. Most customer transactions are supported by technology.

Information technology (IT) has huge benefits for Environmental Public Health programs:

Disclosure of Inspections- inspection reports can automatically be placed on the internet.

Manage Non-Compliance– with Public Health Inspectors/Environmental Health Officers (PHIs/EHOs) conducting 20+ inspections per week, with IT it is easier to track issues requiring a follow-up.

Consistency of Program Delivery- as no two PHI/EHOs conduct inspections in the same way, IT can be used to ensure the same questions are asked by all PHI/EHOs.

Facilitate Communication- effective IT could quickly and accurately send all relevant Environmental Public Health information to the policy makers to help them understand PHI/EHOs work in the field. PHI/EHOs will only need to validate and sign off on the numbers.

The use of information technology within the public health system in Ontario is generally poor. In Ontario, Public Health Inspectors are often not assisted in the field by electronic data collection tools. That data which is collected in the field manually is often entered again by hand into a database and using software which is considered by many as antiquated (not robust or reliable). A few Health Units in Ontario, not satisfied with the status quo, have investigated other technology options for field data collection and management. Other Health Units cite resource limitations as a barrier to implementing other technology options and are waiting for a provincial solution.

Increasingly, governments are requesting program information from Public Health agencies to justify mandated programs and associated funding. In fact, the recently released Ontario Public Health Standards places an emphasis on research and knowledge exchange for informed decision making. It is hard to imagine how a decision maker can be informed without a reliable data set.

Question

Considering the above, what will it take to move the Public Health system in Ontario to consider the use of viable information technology to support Environmental Health programming?

So, what do you think about this? Drop a line to your **Past President Michael Duncan** at pastpresident@ciphi.on.ca

Ontario Branch News

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www.ciphi.on.ca

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Look for our Next Issue…… Fall 2007

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That I have an obligation to the public whose trust I hold and I will endeavour, to the best of my ability, to guard their interests honestly and wisely. I will be loyal to the government division or industry by which I am retained.

That the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

That being loyal to my profession, I will uphold the constitution and By-laws of the Canadian Institute of Public Health Inspectors and will, at all times, conduct myself in a manner worthy of my profession.

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