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MANITOBA

Communities are Partners

Background Report: Workers' Occupational Health and Safety Rights with Newcomers

By Dorothy Wigmore

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Dorothy Wigmore is a long-time occupational health and safety specialist based in Winnipeg. With training in occupational hygiene, ergonomics and work organization/stress, she has been a practitioner, educator, researcher and writer in Canada, the United States and Mozambique. The MFL Occupational Health Centre's first occupational hygienist, she has worked with/for governments, unions, NGOs and universities.

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Introduction: Why This Background Report?

The MFL Occupational Health Centre (OHC) is a unique facility, offering information, training, medical assessments and support to workers since 1983. It is the oldest labour-linked occupational health centre or clinic, and one of the few in its speciality, in Canada.

For 20 of those years, its Cross Cultural Community Development Program (CCCDP) has provided first-language workshops to migrants.[1]

In them, Community Trainers, who have gone through a train-the-trainer program, cover basic occupational health and safety and workers' compensation rights in Manitoba. Despite reaching thousands of newcomers, the Program remains unknown to many health and safety and community development activists and others in the province and country.

With limited staff, no one has had time to compile the Program's history, take an overall look at its accomplishments and challenges, and consider the policy implications of its unwritten history, power-challenging community development model, and newcomers' health and safety needs that the work brings to light.

The result is two documents. This one provides background about occupational health and safety, community development, and data and services available to migrants to Manitoba and Winnipeg. The main report uses the context from this document to frame the history, analysis and recommendations.

This background document was prepared using a variety of search methods, as well as the author's knowledge and experiences from many years in the field, including some as a Safety and Health Officer in the Manitoba Department of Environment and Workplace Safety and Health and original lead author of the 1988 *Health Hazard Regulation*.

In the spirit of community development principles and practices, the Advisory Committee, and OHC staff working them, reviewed both documents in various versions. Their feedback was essential and helpful. The author is responsible for the final versions.

Occupational Health and Safety: What's the Big Deal?

The goal of occupational health and safety (OHS) is to prevent people getting sick, hurt or killed because of their job. The topic is complex, intertwined with many others, including the minefield of workplace "employment relations" and "management rights". Still, the goal is pretty straight forward: no one should die, get sick, or be injured just because they went to work.

In practice, prevention is much more likely to be effective with OHS systems integrated into overall management systems that include recognition of the issues discussed below, and real, effective worker participation. Prevention also requires a comprehensive view of all hazards, their connections and root causes (see Figure 1). Too often, the emphasis is on the visible safety hazards instead of the five health categories, and the real reasons behind hazards (linked to work organisation) are ignored.

It's a Human Right

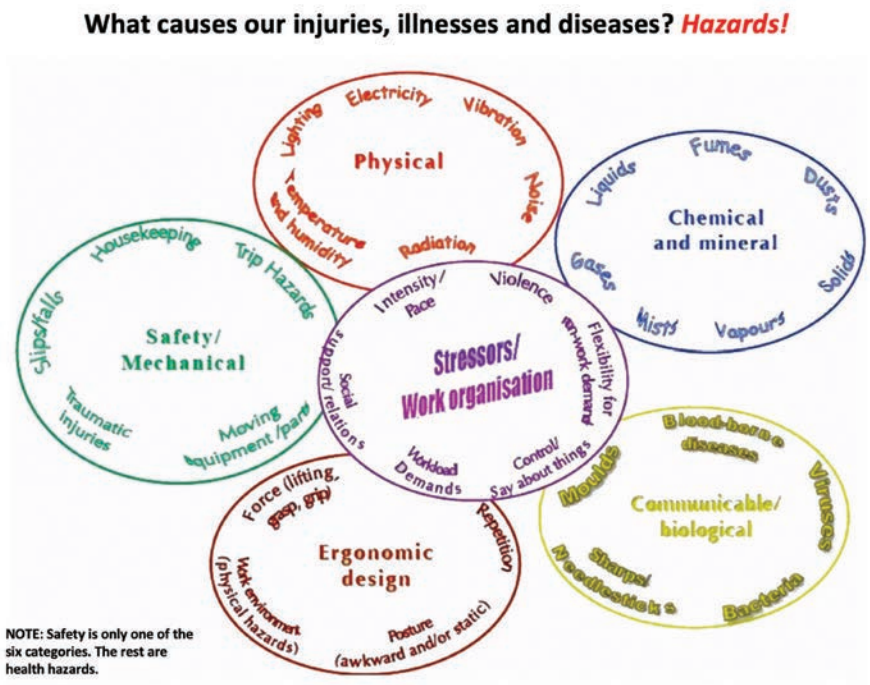
Workers' health and safety is a human right, easily promoted but difficult to achieve. Employers talk about workers being "our most valuable asset", while treating them

> .. just like any other production input (that is) expendable if the return is high enough. The implicit moral commitment to worker welfare is clearly absent. The narrative is highly vulnerable to being unmasked: if workers are so valuable, why is work organized in ways that resulted in widespread injury?[2]

In practice, frequently OHS is treated as a technical, legal or economic issue. Also, too often, "it's just part of the job" if someone is hurt or gets sick, or even if they die from a work-related injury, illness or disease. It's "the price of doing business", often linked to inaccurate descriptors like "worker carelessness", or an "accident".[3]

> This economic perspective dominates the debate about workplace health and safety. It is the "lingua franca" of employers, bureaucrats, politicians, and most academics. .. An alternative advanced by workers views workplace injuries as the result of choices employers make in order to maximize profitability. Contrary to the slogan "safety pays," it is usually cheaper for employers to organize work unsafely. This is especially true if employers can (with the tacit consent of

FIGURE 1 The Six Health and Safety Hazard Categories



SOURCE: Wigmore, D. (2008)

government) pass along the cost of occupational injuries and disease to workers.[4]

The Italian Workers' Model of health and safety used the term "Our health is not for sale". To those workers of the 1960s, this meant that they would not delegate decisions about their health to anyone — doctors, employers, unions, or the OHS professionals and specialists working with them. It also meant that health is not supposed to be part of the deal when selling one's labor to an employer.[5]

Knowing this history and the Scandinavian experiences and practices, Bob Sass talks about workers' "inalienable" rights (i.e., they cannot be removed or transferred).

> Health and safety (i)s to be treated as a good in itself, and the rights attached to it should not be "chopped-up rights to satisfy economic considerations, but should be sort of inalienable rights." Just as it is illegal to sell oneself into slavery in Canada, it should not be possible to sell one's health.[6]

The United Nations Special Rapporteur on human rights and hazardous substances and wastes agrees, emphasising the human rights link to working conditions in his 2019 set of principles:

> 16. Safe and healthy working conditions have been explicitly recognized as a human right since 1966, with the adoption of the

Human Rights Implicated by Toxic Chemicals

Human rights are universal and inalienable. All people everywhere in the world are entitled to them. Any person who has such rights cannot voluntarily give them up. Nor can others take them away from him or her.

Hazardous substances and wastes, including toxic chemicals, implicate a broad range of civil, cultural, economic, political, and social rights. Under international human rights law, States have a duty to protect human rights and businesses have a responsibility to respect human rights, including those implicated by hazardous substances and waste.

UN Special Rapporteur on human rights and toxics
http://www.srtoxics.org/your-rights/

> International Covenant on Economic, Social and Cultural Rights. They are a fundamental aspect of the human right to just and favourable conditions of work. The right to safe and healthy work encompasses many other interrelated and interdependent human rights, including the rights to life, health, bodily (physical) integrity and security of the person. These are indivisible from the rights to information, meaningful participation and the freedoms of expression, assembly and association, as well as the right to an effective remedy.
>
> 17. Although globally recognized for over 50 years, and despite specific efforts in certain countries and contexts, the right of all workers to safe and healthy working conditions, as well as other interrelated and interdependent human rights of workers, continues to remain insufficiently implemented and realized, particularly with respect to occupational exposures to hazardous substances.[7]

It's a Public Health Issue

Occupational health and safety is a component of public health, the:

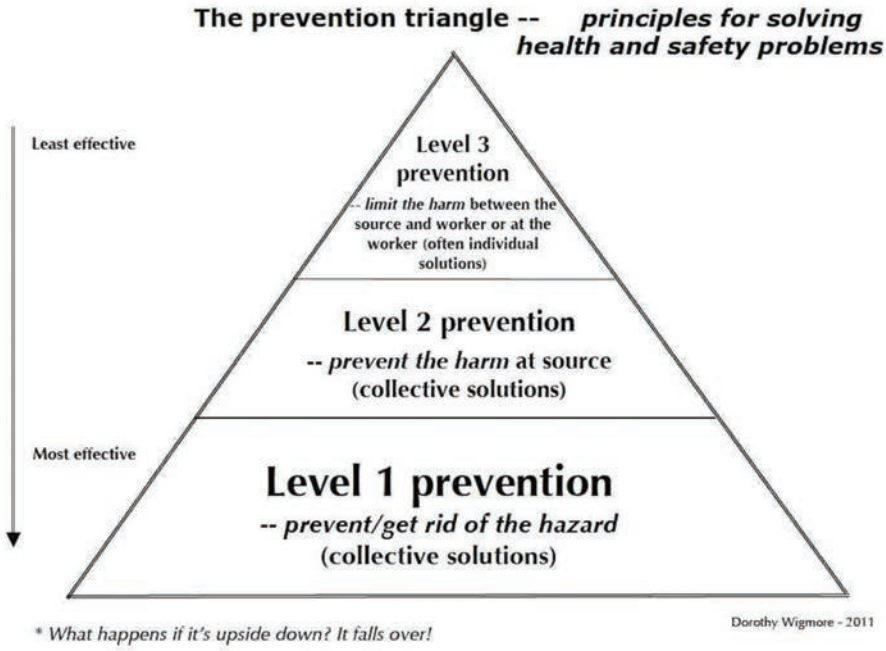
> multidisciplinary approach to the recognition, diagnosis, treatment, and prevention and control of work-related diseases, injuries and other conditions. It is part of public health — what we, as a society, do collectively to assure the conditions in which people can be healthy.[8]

Primary prevention — the best solution in public health — does not occur because of "awareness". That is necessary, but not sufficient. Primary prevention requires eliminating the hazard or finding an "informed substitute" product or method.[9]

Studies show that effective OHS changes are most likely to occur in a workplace because of enforcement with penalties; there is only moderate evidence that awareness activities do that.[10] They also show it requires a systemic approach grounded in the commitment of top management and building on effective prevention programs (required in Manitoba and other jurisdictions). The recent International Organization for Standardization (ISO)[11] and Canadian Standards Association (CSA)[12] standards about occupational health management systems reinforce this, along with the need for true and effective worker participation.

Prevention requires action and commitment. It is about using principles and practices to get rid of hazards, not arguing about the risks[13] involved, focusing on occupational exposure limits, or making protective equipment or gear the first go-to solution. The latter only limit harm, are expensive in the long run, and difficult to enforce. (Instead, specified design, procedures and

FIGURE 2 **The Prevention Triangle**



SOURCE: Wigmore, D. (2008) The Prevention Triangle, based on the Belgium health and safety law. https://www.wigmorising.ca/prevention-principles/

processes are easier to enforce and more likely to provide some protection.[14])

It's a Social Determinant of Health, and a Consequence of Corporate and Political Determinants of Health

From a public health perspective, OHS and other working conditions are parts of the structural and systemic "social determinants of health" — the often-unseen reasons for an individual's or group's health status: the "conditions in which people are born, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels".[15] They lead to the health and social inequities that more and more OHS practitioners are acknowledging amidst international calls for "decent work", with its four "pillars": – employment creation, social protection, rights at work, and social dialogue.[16]

Job-related hazards can affect health directly; physical and organisational working conditions can influence what some call personal choices. This ignores contributors like the links between low income and hazardous work, reduced life expectancy and other health inequities. The connections are leading occupational health and safety practitioners and researchers to say that protecting low-income — often non-unionized and immigrant — workers, in particular, should be a public health priority, since they are commonly caught up by these social, economic and environmental determinants of health.[17]

Others add another dimension, calling working conditions a "commercial" determinant of health — "strategies and approaches used by the private sector to promote products and choices that are detrimental to health" — especially for non-communicable and chronic diseases.[18] Similarly, René Jahiel proposed "corporation-induced diseases":

> diseases of consumers, workers, or community residents who have been exposed in the marketplace, work site, or community, respectively, to disease agents that are part of the products or processes of corporate activity.[19]

University of British Columbia researcher John S. Millar also writes about the "corporate determinants" of health:

> Most chronic disease can be prevented and there is evidence that more investment in prevention can reduce the burden of disease and, in the long term, reduce the costs of health care. Effective prevention of chronic disease requires addressing the "corporate determinants of health".[20]

System-wide corporate determinants of health (i.e., activities) include misinformation, "science for hire" and casting doubt,[21] delaying government action in numerous ways,[22] and exerting adverse influence in coherent ways.[23] They all send a message that public health, including workers' health and safety, has to confront these determinants. As two authors recently said in the American Journal of Public Health:

> We conclude that at the heart of an extremely complex subject (of corporate influence and health effects) lies the nature of power. An effective response to the corporate and commercial determinants of health must address the power imbalance between global corporations, which are accountable only to their owners and shareholders, and governments, which are accountable to their citizens.[24]

Others have proposed being upfront about these corporate influences, calling them political determinants of health (while not touching on occupational health specifically).[25] As one author put it:

> the root causes of health and, thus, health disparities are driven as much by policy— and politics— as by any other cause.[26]

As the person who introduced OHS rights and full coverage for all Canadian workers in the 1970s, Sass has experienced and analysed some of the corporate influences in his activities within Saskatchewan and on the national scene (e.g., as a member of the Board of Directors of the Canadian Centre for Occupational Health and Safety/CCOHS). It led the former Saskatchewan Occupational Health and Safety Branch Executive Director to declare the three R's (rights) have been replaced by the three C's: corruption, collusion and criminality (of manufacturers, governments, employers), particularly when it comes to information about chemical hazards.[27]

It's About Power and Democracy

Workplaces do not reflect society outside their doors. Once someone agrees to work for an employer — whatever the arrangement — they almost always give up most or all of the rights they expect as citizens in a democracy. We're so used to the double standard that the power involved is often the "elephant in the room", rarely named and scary and/or difficult to confront. (U.S. OHS activist Charley Richardson has been one of the few to do this with his "continuous bargaining" approach.[28])

Another result of corporate influence, Canadian and other nations' labour laws give employers "management rights" — i.e., power — to run their organisations or businesses as they see fit, with few limits.[29] Even in unionised workplaces, the usual procedure is to "work now and grieve later", in deference to the management mantra. In authoritarian structures — especially those without effective union representation — speaking up about a health and safety hazard can be interpreted as insubordination, and collective action an intolerable threat to management (and perhaps managing).

Health and safety "rules" provide two exceptions. The right to refuse in Canadian OHS laws is one of the few options a worker has to

say "no" without (technically) being called "insubordinate".

With its broad scope, a worker's right to refuse "dangerous work" in Manitoba offers (usually described as individual) possibilities to stand up to management's power and force change. The law does not restrict refusals to hazards that could cause "imminent danger", like the federal one does; it only requires that the worker "believes on reasonable grounds" that something is dangerous to themselves or someone else.

The other terrain for challenging "management rights" is "participation" in joint health and safety committees, part of an "internal responsibility system". With at least half the members representing workers, management still has its first "kick at the cat" about OHS issues in the framing of problems, discussions about them, and recommendations to the employer. The activities associated with corporate determinants of health — delays, doubt, "science for hire", "it will put us out of business" — play out in these settings. In the end, many employers still dictate what, when, where, and how things are done, constrained only by that duty to "consult and co-operate" with the committee — and sometimes unions — about OHS.[30]

FIGURE 3 **Workers Have a Right to Refuse Dangerous Work.**

SOURCE: Health and safety manual for HEU stewards serving on joint OH&S committees

Power and management rights often interfere with joint health and safety committees' activities. Sass described it this way:

> For committees to work effectively there must be a sharing of power. Management generally views this as an infringement upon its 'management rights'. They resist the extension of worker rights into work environment matters more fiercely than the actual expenses associated with better ventilation or noise reduction programs. Management, on the whole, insists that an organization requires an authoritarian administrative structure if it is to be efficient, and that democracy will not work whether in the public or in the private sector.[31]

He argues that workers need full rights to participate in decision-making around health and safety issues because it is "a higher priority than profit, since it is a question of life and death for workers."[32] Like others (e.g., Steven Deutch[33]), he points to the Norwegian experiences of industrial democracy, where health and safety laws and practices give workers, their representatives and committee members much more power than those in North America or the UK. Sass and others see the need for workplace democracy as the best primary prevention for the health consequences of stressors like lack of control over one's job and the consequences of putting profits ahead of worker's health and safety.

Meaningless and fake participation and/or consultation are common in Canadian workplaces. However, workers can spot superficial participation, and the power behind the "window dressing" when they feel disrespected, see contradictions between "Safety First" signs and

actual practices, are not listened to and are "sensitive to the absence of a democratic component in their workplace". That's what Canadian researchers learned when they tried to introduce a participatory ergonomics program at an Ontario manufacturing workplace. Their recommendation: "commitment to a more democratic process might be a precondition to participative strategies."[34]

In Canada and elsewhere, worker participation is a sticking point in lots of OHS standard-setting and regulatory efforts, as well as individual workplaces. Rarely is "power" mentioned, although "management rights" might come up.

Yet, participatory ergonomics — like the efforts mentioned above — is generally accepted as the best way to fix ergonomic design and related hazards.[35] Using workers' knowledge and experiences is behind the SOBANE method of tackling a wide variety of occupational health and safety hazards (used by the Belgium government and others).[36] And the Canadian Standards Association 2019 version of its standard about occupational management systems reflects debates about worker participation in developing the ISO version. The CSA site notes that the Canadian version made "significant deviations" from the ISO standard to meet objectives including:

> d) to recognize the role of worker representatives in determining the OHS needs of workers;
>
> e) to recognize the requirement to ensure that workers and worker representatives participate in OHS management decision making.[37]

Thus, those who take on health and safety issues are effectively confronting management's powers to control the health and safety — and lives — of those they employ, their families and communities. Workers may not always frame it as such, or talk about workplace democracy, but employers' sometimes-vehement resistance makes it clear how much is at stake.

The "Internal Responsibility System" Doesn't Acknowledge Employers' Power, or Workers' Lack of It

All Canadian OHS laws clearly state employers are responsible for their employees' health and safety, and sometimes that of others (e.g., in Manitoba). Employers must provide healthy and safe jobs and fix hazards; it is a duty, a requirement. Workers' responsibilities are much less: report hazards, and use protective procedures/measures or gear provided. Essentially, the laws — including Manitoba's — say that if you control the workplace (i.e., have those "management rights"), the hazards are your problem too.

However, in workplaces and professional OHS associations, and amongst OHS government officials across the country, the phrase "internal responsibility system" (IRS) often is used to describe a "shared responsibility" for OHS.[38] Manitoba workers are expected to participate through a mandatory joint health and safety committee that provides recommendations but cannot make decisions (if a workplace has at least 20 regular employees). Smaller workplaces (five to 19 regular employees) must have a representative with the same responsibilities and limits as official committees.

Manitoba employers must "consult and cooperate" with the joint committee or representative about a wide variety of things. These days,

FIGURE 4 **A Common — and Erroneous — Message About "Shared Responsibility" for OHS.**

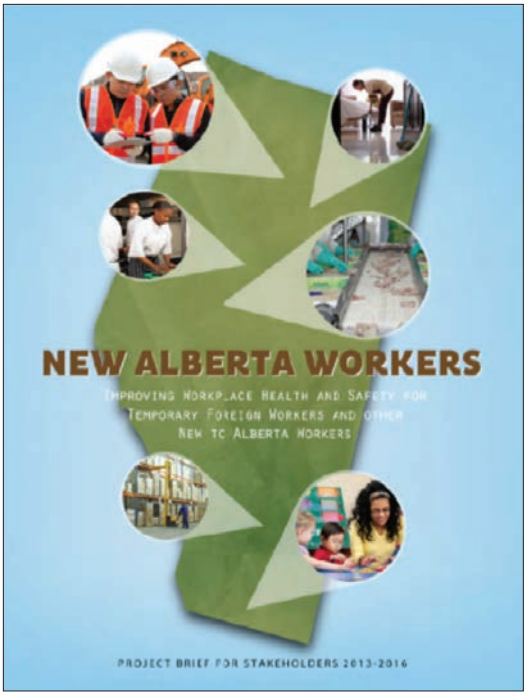
they even have to respond to committee recommendations, but there is no data about how often committees try to use this requirement, or its effectiveness.

Essentially the IRS approach means that workers (and their unions, if they have one) and employers are expected to work together on health and safety issues because they are "everyone's responsibility". Workers and unions are told to "leave your hat at the door" and work for a common cause with management. And since they are "all in this together", health and safety is not supposed to be a bargaining topic. The "workplace parties" should sort out health and safety hazards on their own, without "outside" interference. "External responsibility" — i.e., government enforcement — is a last resort. It is a logical extension of the economic perspective about OHS hazards.[39]

James Ham introduced Canadians to this English approach (from the Robens report behind the 1974 *Health and Safety at Work Act*) in his 1976 report to the Ontario government.[40] However, his key recommendation to include worker auditors with some effective powers in addition to joint health and safety committees was left out of the 1978 Ontario law. Since then, other jurisdictions have copied Ontario's interpretation of an IRS — with joint committees at the centre — usually in guidelines, and sometimes even in law (e.g., the federal OHS law).

In Manitoba, historically government officials and enforcement staff often have presented the IRS as though it is the law, although the phrase is not in the Act or regulations. For example, current SAFE Work Manitoba materials say "The primary role of a safety and health committee is to monitor the effectiveness of the internal responsibility system (IRS) at the workplace."[41]

Despite the distinction about what is in the law, over the years the IRS has greatly influenced provincial government OHS enforcement and information activities. Like other places, OHS activists call it "the eternal responsibility system" and talk about being "consulted to death" in joint committees.[42]



New Alberta Workers was a 40-month program to help workers new to the province to know more about their health and safety rights.

While joint committees are supposed to improve communication about health and safety within organisations, employers continue to control workers' lives. This reality is only partially recognized in an IRS approach; often things are discussed in ways that hide the conflicting nature of workers' and employers' interests and power. Few are honest about the reality.[43]

Sometimes the IRS is challenged. For example, in their *New Alberta Workers* project report, the Alberta Workers' Health Centre recommended the provincial government revise its use of the IRS to "address limitations based on the inequities of power between employees and employers."

> The IRS presumes employee/employer relationships in which workers not only have the capability but the responsibility to "speak up." It does not recognize that workers are often the least empowered in the system, and yet are tasked

with holding their employer and the government accountable to ensure and enforce the conditions for health and safety in the workplace.

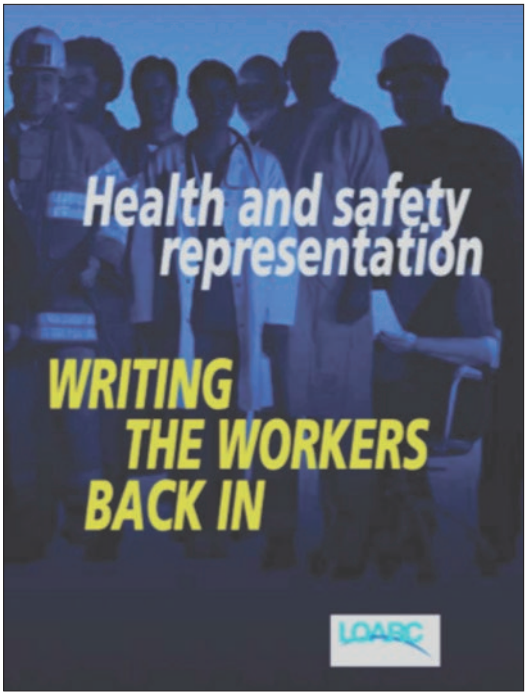
The IRS does not recognize social conditions of worker vulnerability, including ethnicity, "race", gender, ability, immigration status, or precarious work, as factors impacting or precluding their ability to participate freely and equitably in the system.[44]

In contrast, in 2017 the Labour Caucus of the provincial Advisory Council on Workplace Safety and Health supported "entrenching the principles of the Internal Responsibility System" into the provincial OHS law's objects and purposes.[45] The Council's report to government mis-represents the intentions of those writing Manitoba's law in the 1970s,[46] saying

(t)he IRS is a foundational principle of Canadian occupational safety and health legislation, and provides an overview of responsibilities at all levels in the workplace. The Labour Caucus supported this addition, noting the term is often used in publication education materials but is not found in legislation.[47]

Employer representatives objected. Whether it was their stance or the note-taker's, the Council's submission suggested "changing the objects and purposes of the Act may have significant unintended consequences, and does not provide anything additional to the Act or its administration." The submission referred to inclusion possibly providing "clarity on shared responsibilities for safety and health in the workplace", also mis-representing the law's actual content.[48]

In another view of worker participation and representation, the Labour OHCOW Academic Research Collaboration/LOARC project found that worker committee representatives can be effective if they are "knowledge activists". "Writing the workers back in" involves 10 steps: research, work with and outside committees, mobilize influence, listen to and engage other workers, address authority, build trust, be assertive, build solutions, use inspections and minutes, and use the law strategically.[49] This kind of committee member is somewhat similar to James Ham's "worker auditor".



Workers' OHS Rights in Manitoba

Recognising the determinants (without naming them explicitly) and the power differential in job settings, the UN Special Rapporteur named 15 principles for workers' OHS-related rights. Rooted in nearly 25 years of work, including concentrated consultations around the world, they include:

- Every worker has the right to know, including to know their rights.
- Workers or their families should not bear the burden of proving the cause of their illness or disability to access an effective remedy.
- Depriving workers of their right to safe and healthy work should be a crime.[50]

Like every human "right", health and safety rights, laws, regulations and workplace practices did not fall from the sky. They became law and "real" only

after struggles, deaths, illnesses, and more.[51] Like others, the Manitoba health and safety law puts them into effect with corresponding employer duties, along with the general duty to protect workers' health, safety and welfare.

Laws are tools (not always the most useful ones), setting the minimum expectations about a particular topic. Some of the UN principles *are* reflected in *Manitoba's Workplace Safety and Health Act*, passed in 1976 and revised several times since. Informed by the UK's 1974 *Health and Safety at Work Act* and Saskatchewan's 1972 law, it was one of the first composite OHS laws in Canada. In a change from the past, all workers — not just those in mining or construction jobs — were covered, and had rights to know, participate and refuse around OHS issues.

One of the most progressive in the country, Manitoba's law makes it clear that:

- prevention is the goal;
- "health" is "the condition of being sound in body, mind and spirit, and shall be interpreted in accordance with the objects and purposes of this Act" (the World Health Organisation's definition);
- employers must obey the law, and ensure workers' health, safety and welfare;
- workers have four rights, to:
  - know about job-related hazards (through information, training and competent supervision),
  - participate in things related to OHS (usually just through joint health and safety committees),
  - refuse tasks or jobs they believe are dangerous to their own or others' health and safety, and
  - no "discrimination" for health and safety activities, including asking questions or making complaints; and
- government officials have the authority to order employers to obey the law, fix hazards and fine or take them to court if they don't.

However, there is no evidence that Manitoba workers benefit from the third principle listed above, about treating some OHS situations as a crime. Despite the federal "Westray Bill" making it possible to take employers to court under the Criminal Code for killing workers, and the province's own law about employers' duties to provide healthy and safe jobs, a 2017 CBC investigation:

> .. revealed that *not a single Manitoba company* has been charged with criminal negligence for safety violations after a worker's death on the job, and provincial fines fall well short of the national median penalty (of $78,000 compared to $97,500).[52]

The *Act* and regulations do require many employers to have overall prevention programs and "safe work procedures" around a variety of hazards, including musculoskeletal injuries. Of particular concern to newcomers, revisions to the Act now require that employers give all "new"[53] workers an orientation that covers specifics about the job they will do, including:

- the employer's duties and workers' related legal rights and responsibilities;
- the hazards to which the worker may be exposed (e.g., chemicals, safety, ergonomic design, stressors) and the prevention and/or control measures provided (e.g., isolation, ventilation, protective gear, breaks);
- procedures to report hazards, illnesses and injuries; and
- how to refuse dangerous work and reach the safety and health committee or representative (if either exist).[54]

There are no public reports about how often these provisions are found wanting in Manitoba workplaces.

Statistics Don't Tell the Real Story

Despite lofty goals and legal requirements, the IRS, workers' and unions' efforts, and government enforcement, every year on April 28th — the national Day of Mourning for workers killed and injured on the job — names and numbers are cited to describe the toll that jobs take on the province's workforce.

In 2018, 27,920 injuries were reported and accepted by the provincial Workers' Compensation Board (WCB), 13,035 of them involving time off work. Musculoskeletal injuries — the provincial term for repetitive strain injuries, also known as cumulative trauma disorders — accounted for 37 percent of all time-loss numbers. The Board recorded 11 occupational disease deaths (all but one from asbestos-related diseases) and 14 acute fatalities.[55] An outside analysis found that, between 2012 and 2017, Manitoba had the highest 5-year average injury rate (3.00 per 100) among provinces with more than 100,000 workers. (Only 79 percent of the provincial workforce is covered by workers' compensation.[56])

Health and safety statistics are "people with the tears wiped away", as occupational physician Irving Selikoff frequently said. They also are notoriously inaccurate. For example, the International Labour Organisation estimates that for every traumatic fatality, there are six occupational health deaths world-wide, more in countries like Canada where acute fatality rates have decreased.[57] That would mean there were at least 84 job-related disease deaths in the province in 2018. Using a 2018 Canadian analysis, fatalities would be at least between 250 and 325, not 25.[58]

Reasons include under-reporting, compensation claims suppression, occupational diseases going unrecognised or uncompensated, and workers' fears of speaking up lest they be punished and/or lose their job. In these days of precarious employment — whether it is temporary, contract, short-term or migrant — those fears are particularly prevalent.

What is dismissed as "nothing" or "not too bad" one day can turn out to be a serious injury or illness in a few days or week. Long-term systemic effects to the body, particularly from continuous low levels of exposure to hazards, can be difficult to link to an individual outcome. The too-common stressors of low control, high demands, and little respect and/or support do not just lead to mental health issues but can complicate people's ability to resist the effects of other hazards or set them up for adverse effects.[59]

It is even more likely that newcomers — unfamiliar with Canadian or Manitoban laws, workers' rights and the many struggles to win them, not to mention being afraid of deportation or other retaliation for speaking up — will just keep working to keep a job, which is often difficult for them to get. As Barnetson puts it:

> Employers' power has both legal and practical limits — workers pushed too hard resist in a variety of ways. Yet, when the whip of hunger is combined with the legal right to manage, workers mostly fall into line.[60]

What Does it Mean for Newcomers?

Newcomers are in a vulnerable position due to many systemic factors (e.g., gender, racism/racialisation,[61] immigration status) and situations in the nature of their jobs (e.g., low wages, few or no benefits, little job security or say about what they do). Thus, the term "vulnerable" is not about individuals or their failings, but the systemic factors and situations facing them.

> Vulnerable workers are those whose work is characterized by low wages or insufficient hours of work, few or no benefits, little job security and minimal control over their work conditions. They are disproportionately women, immigrants (both newcomers and those established in Canada) or racialized persons.[62]

Like others new to a particular job, recent newcomers are more likely to have a work-related injury than other workers and immigrant men

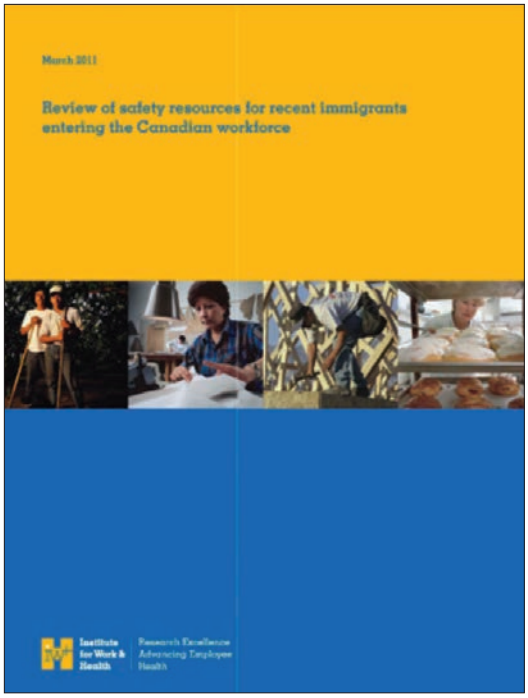
are twice as likely to seek medical care for work-related injuries than Canadian-born men.[63] (Temporary workers — i.e., those employed in precarious jobs — and those facing serious hazards also are more likely to be hurt or get sick.[64])

There is little disagreement that this data under-estimates the toll. Based on accepted workers' compensation claims, it assumes injured or sick migrants make it to, and through, the workers' compensation system. However, they can have difficulty accessing the system and using it, because of language barriers, poor knowledge about their rights, and lack of information from employers about reporting systems.[65]

In a 2012 report about newcomers dealing with job-related injuries, Kosny and colleagues found "reporting an injury was made more difficult by their insecure labour market position and the financial demands of settlement." Although their issues were similar to those of other workers, they seemed to be magnified for migrants. They worried injuries that affected their ability to work "would spell financial calamity for themselves and their families". Unclear about their rights and unfamiliar with the workers' compensation system, they ended up relying on their employer or health care provider for information and to file claims. If they did get to the workers' compensation system, there were many language-related difficulties (e.g., no access to interpretation services) and communication difficulties often complicated their claims.[66]

Until a 2010–2011 scan, there was little known about how newcomers are prepared for work in the Canadian labour market. In this activity, researchers at the Toronto-based Institute for Work & Health (IWH) looked at employment standards, occupational health and safety and workers' compensation. Their findings paint a disturbing picture.

Welcome guides were rarely helpful. Translation into the languages of newcomer communities was uncommon. (Manitoba then only had materials in Tagalog.) Most of the information



newcomers could find on websites were about employment standards; workers' compensation got the least attention, often just a mention of the provincial agency and how to reach it. The materials usually were short fact sheets; there were some guides with information about more topics but not necessarily great depth. The few "interesting initiatives" found included the MFL Occupational Health Centre's Cross Cultural Community Development Program.[67]

Language was a key problem in that scan. It also was a key factor in another IWH study done about the same time which described serious OHS consequences of language barriers facing newcomers:

> The language issue also heightens concerns about immigrants' knowledge of their rights, access to information about safe work practices in their mother tongue, and ability to refuse unsafe work.[68]

In their 2018 "scoping review" of English-language studies about injuries involving newcomers to Canada, University of Calgary research-

ers found these language barriers were the main reason behind immigrants' work-related injuries. When employers and workers can't communicate, injury and delayed workers' compensation are likely. Lack of formal training was another leading cause of injuries among newcomers in the workforce.

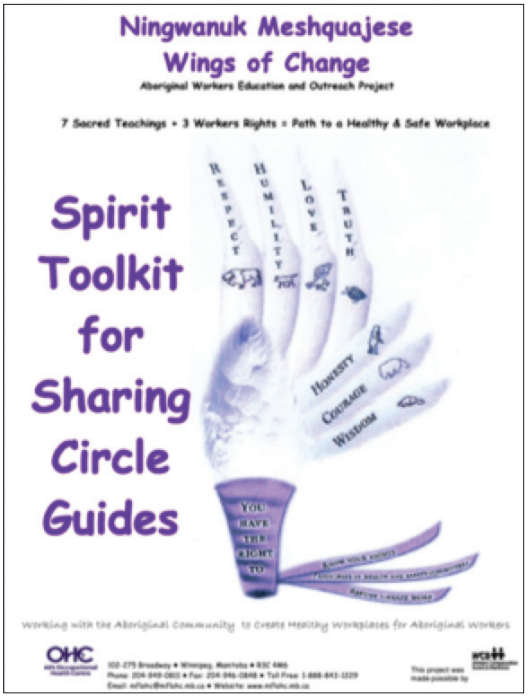
> When joining a new workplace, immigrant employees should be educated by their employers about OHS issues, regardless of their immigrant status. Employers should ensure their policies benefit the workers and their occupational health.
>
> ... OHS information should be available in the languages spoken by immigrants. Since injuries are costly, translating OHS regulations and making them more accessible to immigrant workers would be an important step for employers and employees. Integrating different languages and reducing cultural barriers so that training can be completed successfully would lead to a safer workplace for all.

Like others, they also found that mismatches between jobs and education was:

> a sizeable factor for injury among Canadian immigrants. It was found that immigrants who had a higher education than what the job required (i.e. were overeducated) were twice as likely to be injured compared with participants whose education matched the job requirement.[69]

Ontario researchers recognise the power differential that newcomers, in particular, face on the job. Combined with other factors, it creates a "perfect storm" that "may make recent immigrants and refugees particularly vulnerable to poor working conditions and work injury":

> Having knowledge about rights and responsibilities and OHS does not guarantee that newcomers will be safe at work. Precarity in the labor market and financial pressures made it difficult for newcomers to speak up and protect



> themselves when asked to do something unsafety when they were mistreated. .. It also is important for policy-makers and government bodies to understand how system-level factors affect the delivery of safety training and worker health.[70]

This is consistent with a 2010 study that found five factors to explain why injuries more likely common amongst newcomers. They are: working in a non-unionised job, physically-demanding occupations, working in small workplaces (with less than 20 employees) and non-permanent work. The authors suggested it is worse, given "power differentials" that reduce the migrants' odds of refusing work or pursuing compensation. They fear losing their job or being seen as a "trouble maker", partly because they need income to the deal with the financial strain of resettlement.[71] The same issues about power came up some years later in another study.[72]

There are parallels between newcomers' reluctance to speak up and that of Indigenous workers, as the OHC's Wings of Change project discovered. (In the latter case, it often was one remnant of residential school experiences, where speaking

FIGURE 5 **A Litany of Physical and Mental Health Issues — Physical Aches and Pains**

SOURCE: Ng, W., et. al. (2016) 'Working so hard and still so poor!' A public health crisis in the making: The health impacts of precarious work on racialized refugee and immigrant women.

FIGURE 6 **A Litany of Physical and Mental Health Issues — Emotional and Mental Stress**

SOURCE: Ng, W., et. al. (2016) 'Working so hard and still so poor!' A public health crisis in the making: The health impacts of precarious work on racialized refugee and immigrant women.

up or speaking one's language could have serious adverse consequences.) It was part of the learning associated with the *Spirit Tool Kit*.[73]

A 2019 study pulled together some of the complex intertwined challenges facing many newcomers to Canada, including:

- it is difficult to find good quality jobs when credentials from outside Canada are not recognised, and systemic racism and language barriers exist;
- their social networks are few;
- they lack Canadian experience, often demanded in job descriptions;
- they are not "fully proficient" in English or French;
- many end up in "survival jobs", ones they had never done before, concentrated in non-unionised sectors, often part-time or temporary, and without benefits like pensions or health insurance;
- the jobs were often precarious and hazardous, more likely to be physically-demanding involve shifts and be in small workplaces;
- they are less likely to be trained, compared to Canadian-born workers; and
- refugees "often end up in the most precarious work situations", especially if their flight didn't give them a chance to prepare for work and living in Canada.[74]

Building on previous studies and activities, they described the difficulties newcomers face at work, in terms of health and safety, including:

- recent immigrants and refugees may not get or understand training, or know about their rights;

- in Ontario, fewer recent immigrants and refugees know about, or have had, mandated awareness training (after the province introduced it in July, 2014);
- they may not know about the hazards of their job, so they don't ask the employer about training or bring up health and safety issues in general;
- fearing they would lose a job, they were "reluctant to speak up when asked to do something unsafe or when working conditions are poor"; and
- those who find jobs within their communities "can also face poor working conditions and be exploited due to cultural dynamics and power differentials between themselves and the employer".[75]

A gender lens, combined with understanding racialisation, adds to our understanding of work life for newcomers. In 2015, Statistics Canada reported racialised persons had a median income of $25,514, only 69.8 per cent of white persons' median income of $36,538; the greatest impact is on West Asian, Black and Chinese Canadians into the second generation of immigrants.[76] The disparities reflect lower-wage jobs, often associated with more hazardous work.

Precarious work becomes a trap for racialised women in particular, with lots of individual and public health consequences. Seemingly-neutral settlement programs "are deeply implicated in (re)producing and maintaining the gendered and racialized segregation of the Canadian labour market", effectively channeling immigrant women into feminized and racialised jobs (e.g. settlement services, childcare, etc.).[77] (Graphics from the report in Figures 4 and 5 present the physical and mental injuries reported by female Toronto racialised newcomer workers.)

About the same time, focus groups with refugee women in southern Ontario made clear the links among gender, immigrant status and jobs with "power dynamics". Women talked about lack of knowledge about how to make their way through Canada's employment systems. They also felt settlement workers didn't have enough in-depth, one-on-one interactions with them, leading to little or no follow-up and being passed off to other organisations.[78]

An earlier study used an intersectional approach and in-depth interviews with Toronto racialized immigrant women who had difficulty getting stable jobs matching their education and/or experience. Researchers found that the generic settlement job search processes meant women tended to take more precarious, low-skilled positions, compared to other immigrants, and were either under- or unemployed. Like those in the study by Ng and her colleagues, there were direct physical and mental health for participants and their families directly (e.g., through social isolation and frustration) and indirectly through poor quality jobs.[79]

Not surprisingly, the lack of training and knowledge of hazards and rights can put newcomers into the category of "vulnerable workers". Based on their work about newcomers, the IWH developed a health and safety vulnerability measurement tool, to identify jobs likely to cause injury, and the hazards involved. With prevention of injury and disease in mind, and protections in place for hazards that cannot be eliminated or substituted out, they define vulnerability as exposure to hazards without protection.

Prepared with input from policy makers, employers, workers, and representatives of employers and workers, and now used by the Ontario government,[80] the four dimensions start with the presence of hazards (including harassment/bullying) combined with other factors:

- inadequate workplace policies and procedures to prevent/reduce hazards;
- lack of worker awareness about hazards and their OHS rights and responsibilities; and/or
- worker "empowerment" to protect themselves (e.g., speaking up or refusing

dangerous work, without fear of retaliation).[81]

The instrument informed a study published in 2018. The four dimensions were present for many, indicating "most newcomers experience multiple forms of vulnerability", making their integration into the workforce and ability to deal with health and safety hazards difficult and dangerous.[82]

The *OHS Vulnerability Measure* could be useful "as a driver of OHS vulnerability" to help identify and improve the conditions for newcomers' health and safety.[83] The authors suggest a wide variety of organisations, unions, and employers can use their guide and worker surveys (in English and French).

In doing so, responses should not be added up. Instead, answers to each section provide clues about which dimensions are most relevant for particular workers. For example, the researchers found that policies and procedure differences depend on business size, while "empowerment" is least likely for recent immigrants, and temporary workers are most different from permanent workers in terms of awareness. Similarly, a focus on awareness could focus SAFE Work Manitoba on different sectors for a campaign around policies and procedures, while the Workplace Safety and Health Branch could know more about what to look for if they were inspecting a workplace in a specific sector.[84]

The IWH researchers say the links between awareness of hazards and rights and "empowerment", are key. The Alberta Workers' Health Centre Executive Director agreed in his reflections on the *New Alberta Workers* project. Jared Matsunaga-Turnbull says knowing your rights is one thing but "agency to actually move forward on something" is different.

> (F)or me, health and safety cannot be separated from the power structure of a workplace. A lot of systems rely on workers having a voice in the first place to say "I've got an issue that's particular to me." So you're only hearing those issues if someone has the power to actually raise them in the first place.[85]

In a follow-up conversation, he said that education and knowing one's rights are necessary but not sufficient. "Knowledge is not power; power is power", he said, citing a phrase Sass often used. In current discussions about the "choices" workers have about what tasks they do — a myth for many — education doesn't equal empowerment, "because you need to look at the system you're in. If you can't participate and the consequences are so dire, you won't participate. You need to have a path (to use your rights)."

These kinds of observations (consistent with the earlier section about power) led the CCCDP to Michael Lerner's "surplus powerlessness" approach to job-related stress and strain. As a helpful framework to understand the use of power and degree of participation around OHS issues, it informs the CCCDP's community development model. Lerner's thesis is that workers often believe they have less power than they actually do. This can prevent them from taking individual and/or collective action to improve their lives, and sometimes to turn on others with whom they have much in common.[86]

The MFL Occupational Health Centre[87]

The MFL Occupational Health Centre (OHC) opened in 1983. It was largely the labour move-

Manitoba Premier Howard Pawley, MFL President Dick Martin, and OHC's first Executive Director, Lissa Donner, at the 1983 opening of the Occupational Health Centre.

ment's response to the failure of company doctors and the Workers' Compensation Board to prevent and/or properly inform workers about lead poisoning in local foundries.

The original idea came from Luis Rufo, who became the local business agent for the International Moulders Union shortly after the *Workplace Safety and Health Act* was passed in 1976.

For years, workers at the Canada Bronze foundry were getting sick. Sometimes, they were put on workers' compensation for lead poisoning, without information about the harm and few consequences for the company poisoning them. Rufo worked with the Manitoba Federation of Labour (MFL) and the Canadian Labour Congress (CLC) to provide his members with OHS education and current information about lead. They focused on the "sick workplace" and how to prevent workers becoming ill. So did Dr. Percy Decter, who became the workers' trusted physician, giving them their results and information about how high lead levels could affect them.

In November, 1979, Rufo presented the provincial government with a proposal to set up an industrial health clinic, writing:

> Once a doctor is on contract to a company, workers' confidence in their impartiality is lessened. .. (It was) not until after doctors outside of the industry committed themselves to determining the extent of the medical problems in the lead-using industry did we realize the major extent of the problem.[88]

The idea was to have a clinic:

- providing medical exams and information for workers concerned about their occupational health;
- giving independent support for health care practitioners who wanted to focus on occupational health;
- having a mobile clinic to travel to specific high-hazard sites; and
- funded initially by the province and then by assessing employers, similar to how the workers' compensation fund works.

When the Conservative government and premier Sterling Lyon said no, Rufo went to the MFL's new Health and Safety Committee, chaired by Jay Cowan. (A Steelworker from Thompson, he then also was the provincial NDP's health and safety critic, and later, the minister of Environment and Workplace Safety and Health, from 1982 - 1983.) Cowan worked with MFL president Dick Martin — also a health and safety activist in the same Thompson, Manitoba Steelworker local union.

In a classic example of union solidarity, Martin led the effort to establish a workers' occupational health clinic. It included a fund-raising campaign that collected more than $230,000. The MFL Occupational Health Centre (OHC) opened in April, 1983 in a Winnipeg inner city building renovated by volunteer labour.

It wasn't easy going at first. Popular with workers, the provincial Medical Association tried to argue that the OHC doctors were not in a traditional physician-patient relationship, but "third parties". The first physician, Linda Rae Murray, had to appear before the Standards Committee of the College of Physicians and Surgeons of Manitoba to explain occupational medicine's importance and practices. The College agreed her relationship with patients was no different from other situations.

The Centre has always had occupational health physicians and nurse practitioners (there are two of each now), and the finance/office administrator has been there from day 1. The other kinds of staff have changed over the years. There were occupational hygienists from 1986 until 2003. Since 1999, there have been three ergonomists. The latest Resource Centre coordinator started in 2008. It now has its seventh Executive Director. The second Health Educator started in 1999, and the Community Development Worker was hired 2008; they are responsible for the Cross Cultural Community Development Program (CCCDP).

Over the years, the Centre has supported workers individually and in groups; some have been patients while others came looking for information, support or workshops. Sometimes staff also have worked with their employers and/or unions. They have advocated for changes to health and safety and workers' compensation laws and regulations, produced fact sheets and dealt with topics including:

- repetitive strain injuries (sometimes called musculoskeletal disorders or injuries) and ergonomic solutions;
- stress-related issues (e.g., MTS operators affected by electronic monitoring, healthy workplaces, violence and bullying, use of the new Canadian Standards Association *Psychological health* standard);
- occupational diseases, and their underreporting;
- child care centre hazards, particularly ergonomic design;
- occupational health and safety for Indigenous workers, linking Aboriginal sacred teachings with legislated worker rights and health and safety topics in the Ningwanuk Meshquajese/Wings of Change project that developed the *Spirit Toolkit*;
- indoor air quality (IAQ) issues (often with groups of workers);
- a variety of chemical, biological and physical hazards (e.g., metalworking

Guiding Principles

The Occupational Health Centre (OHC) is a worker-centred community health centre committed to ensuring that workers' health is always our main priority.

OHC is committed to providing accessible services and programs for all workers in Manitoba and to reduce barriers workers experience in their workplaces.

OHC believes workers should always participate in decisions that affect their health and safety. We recognize workers are diverse and have particular needs according to their gender, language, culture, religion, physical or mental ability, economic status, level of education, and immigration status and are committed to respecting, and accommodating these differences appropriately.

MFL Occupational Health Centre, 2020

fluids, communicable diseases, weather extremes);

- building effective health and safety committees;
- workers' compensation claims suppression; and
- young workers' issues.[89]

Now in its 35th year, the Centre has outlasted other occupational health clinics or centres, and inspired others (e.g., in British Columbia) to have similar facilities.

The Alberta Workers' Health Centre, started in the same year, has not had medical staff for years. Instead, it concentrates on "information, education. and empowerment for workers" in the province, unionised or not.[90] In Ontario, the Occupational Health Clinics for Ontario Workers (OHCOW) opened their first centres in 1989, building on work done by Stan Grey, USW Local 1005 and activist doctors in Hamilton in the early 1980s. With clinics in seven cities now, and another opening soon, OHCOW just celebrated its 30th anniversary.[91]

At the OHC, "Tuesday morning" presentations, which Linda Rae Murray started in the 1980s, continue. A new health educator is working on a five-year federally-financed Workplace Sexual Harassment project in co-operation with the Sexuality Education Resource Centre (SERC) and Klinic Community Health Centre. Nurse practitioners are collaborating with the Canadian Mental Health Association to prepare and deliver the *A Hazard is A Hazard: Workplace Psychological Health and Safety* course for SAFE Work Manitoba. Ergonomics remains a core topic. There is no occupational hygienist.

Despite all the other activities, the Cross Cultural Community Development Program topped the OHC 2018–2019 training and education numbers; 31 percent of all participants — 735 — were in workshops about/for migrants and newcomers.[92]

Community Development Methods

It's About Real Participation, for Change

The Cross Cultural Community Development Program (CCCDP) deliberately uses a "community development" approach, focused on capacity building and using community leaders to deliver first language workshops after their own train-the-trainer workshops. The approach guides its process and activities.

Community development definitions abound, depending on the source (e.g., the World Bank, community participatory research practitioners, health promotion practitioners, community organisers). For example, the oft-cited World Health Organisation's *Ottawa Charter for Health Promotion* says:

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities — their ownership and control of their own endeavours and destinies.
>
> Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.[93]

Table 1 compares community-based and community development work.

Capacity building — defined as the "increase in community groups' abilities to define, evaluate, analyse and act on health (or any other) concerns of importance to their members"[94] — is key. The process increases assets and attributes upon which communities can draw to improve their lives. It is a means, and an end, creating separate objectives parallel to program goals and objectives.

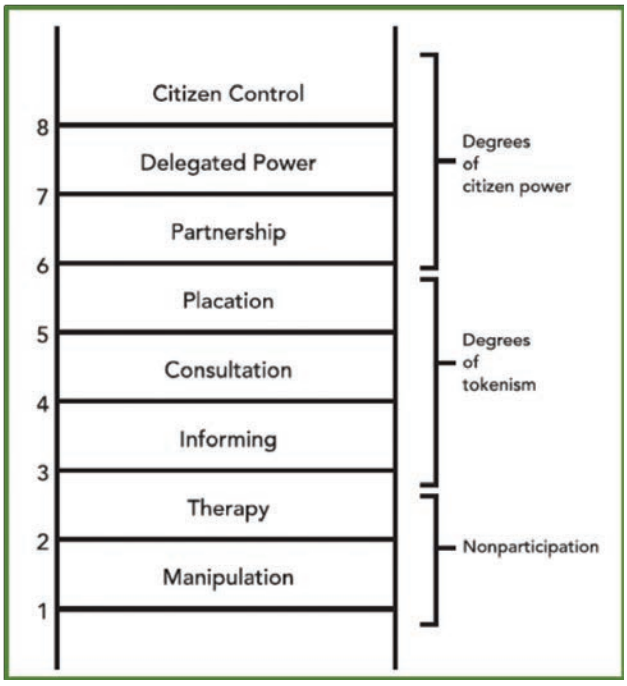
At its core, community development is about community (social and/or geographic, defined by norms, standards, mutual activities, etc.), relationships, and values. It goes beyond individual situations to take on structural issues of power, participation, and democracy. It's about the less powerful having an effective and respected voice that contributes to, and makes, decisions affecting their lives. It's about confronting "power-over", and being truly empowered (i.e., having

TABLE 1 **Comparing Community-based with Community Development Work**

Community-based Work	Community Development Work
An issue or problem is defined by agencies and professionals who develop strategies to solve the problem and then involve community members in these strategies. Ongoing responsibility for the program may be handed over to community members and community groups.	Community groups are supported to identify important concerns and issues, and to plan and implement strategies to mitigate their concerns and solve their issues.
Characteristics:	**Characteristics:**
• decision-making power rests with the agency	• power relations between agency and community members are constantly negotiated
• the problem or issue is defined by the agency	• the problem or issue is first named by the community, then defined in a way that advances the shared interests of the community and the agency
• there are defined timelines	• work is longer term in duration
• outcomes are pre-specified, often changes in specific behaviours or knowledge levels	• the desired outcome is an increase in the community members' capacities behaviours or knowledge levels
	• the desired long-term outcomes usually include change at the neighbourhood or community level

SOURCE: Global Community Development Exchange (2019) *What is community development?* Adapted from Labonte, R., 1999. Found at https://globalcommunitydevelopmentexchange.org/2019/03/25/what-is-community-development-2/

FIGURE 7 **The Ladder of Participation**



SOURCE: Arnstein, S. (1969) The ladder of participation, *A Ladder of Citizen Participation*.

power), trusted and recognised for your knowledge, which comes from experience). The "community" defines tasks and evaluates the results.[95]

Participation is directly related to power, as Sherry Arnstein's well-known 1969 "ladder of participation" shows (see Figure 6). She describes citizen participation as "the redistribution of power that enables the have-not citizens, presently excluded from the political and economic processes, to be deliberately included in the future." The result can lead to "significant social reform" allowing the citizens to share social benefits.[96]

Andrea Cornwall's "unpacking" participation makes clear that "being involved" does not necessarily mean just having a voice in a process. It needs to be translated into influence with efforts from below and above, to avoid self-exclusion (e.g., from frustration of being "consulted" without seeing results, being silenced by more powerful voices).[97]

Finally, community development has a history in OHS activities:

> A community-based participatory approach is useful in reaching many low-income workers, especially those workers whose employers are unwilling or unable to address occupational safety and health issues (such as small business owners) or for workers who may feel intimidated at the workplace. They are also effective in developing education and outreach programs that overcome the cultural, language, and literacy barriers that limit the effectiveness of some workplace training programs. Finally, by building local knowledge and leadership these approaches help to create sustainable programs.[98]

Community Development Tools — Train-the-Trainer and Participatory Methods

Community development tools or methods include peer educators. They may be called community health workers or promotoras (as they're known in Latinx culture), or refer to people who have gone through a train-the-trainer program.

There is a long-standing history of incorporating participatory methods and train-the-trainer (TTT) approaches to deliver health and safety workshops to a wide range of workers in Canada, the United States and the United Kingdom. For example, through the Workers' Health and Safety Centre, since the 1980s Ontario has had a large contingent of workers who provide OHS and workers' compensation workshops to co-workers and others in their area; the Centre staff also provide TTT workshops for unions or workplaces that request it.

Canadian unions — e.g., the Canadian Union of Public Employees (CUPE) — have used participatory methods and TTT programs for years.[99] However, current Canadian examples often are difficult for non-members to discover.[100] Other organisations (e.g., workers' centres, labour councils,[101] some community health centres[102]) also use the methods. In a community-focused approach, York University's *Immigrants and precarious employment* research project[103] developed a popular education workshop manual — including a useful "Precarious Work Wheel" for their activities with recent Caribbean and Latin American immigrant workers in the Greater Toronto Area in the late 2000s.[104]

In the United States, the following are examples of organisations known for using the methods (sometimes called popular education) or where their use of them has been studied/evaluated:

- Arise Chicago Workers' Center (https://www.arisechicago.org/);
- IDEPSCA (the Instituto de Educacion Popular del Sur de California, http://www.idepsca.org/HealthProgram);
- Highland Research and Education Center (the home of much inspiration for participatory/popular education, including Rosa Parks' "sit down", https://www.highlandercenter.org/);

- ICWUC Center for Worker Health and Safety Education [https://hsed.icwuc.org/ with partners including five national unions, the Coalition of Black Trade Unionists (CBTU), the University of Cincinnati Department of Environmental Health, the Labor Council for Latin American Advancement (LCLAA), and the National Council for Occupational Safety and Health/NCOSH)];
- National Council for Occupational Safety and Health/NCOSH (http://nationalcosh.org/) and COSH groups (e.g., MassCOSH, PhilaPOSH, New Jersey WEC);
- National Institute of Environmental Health Sciences' Worker Training Program (NIEHS WTP (https://www.niehs.nih.gov/research/supported/dert/wet/index.cfm);
- UC Berkeley Labor Occupational Health Program (LOHP, http://lohp.org/) and UCLA Labor Occupational Safety and Health Program (LOSH, http://losh.ucla.edu/);
- University of Illinois Chicago Center for Healthy Work (http://www.publichealth.uic.edu/healthywork); and
- Workers Center of Central New York (https://workerscny.org/en/home/) .

Evaluations confirm the effectiveness of TTT and participatory approaches, especially in OHS activities.

> Workers trained by their peers in a Michigan UAW-GM ergonomics education program were as knowledgeable and skilled as those trained by university instructors, but workers were more satisfied with the training provided by their peers than by trainers with a university background. In this program, trainers could adapt education methods to the variety of learning styles among workers in their department, bringing technical information to life.[105]

Chicago researchers took a community-based participatory research approach to get workers' centres in seven cities to recruit 32 Spanish-speaking day laborer worker leaders to deliver the federal Occupational Safety and Health Administration (OSHA) 10-hour construction health and safety course to peers. The WLs also helped develop the curriculum. About 450 workers were trained.

> (There was) evidence of training effectiveness in this study — an increase in knowledge, intention to change behavior at work, and descriptions of behavioral changes.[106]

Finally, a unique use of promotoras in a pilot health and safety training program for Latino forest workers helped reduce fear of retaliation and changes to worker behaviour.

> (T)he Sí, Sé program was successful in developing leadership among the promotoras and establishing them as resources in the community. The program also impacted the workers themselves.
>
> (W)e found that community capacity to address working conditions increased among both promotoras and workers. Leadership and access to information increased, with the promotoras playing a pivotal role, and workers' awareness and knowledge of workplace health and safety rights and resources increased. Second, while fear of retaliation was a barrier to workers acting on this knowledge, the promotoras were able to support several workers in addressing specific workplace issues.
>
> (A quote from a promotara) Even when a mayordomo (supervisor) came in during one of our workshops and the workers were nervous, I was not. Before I was afraid of them, but now I am not. You have to learn and help. You have to talk to people.
>
> Our results are consistent with other studies that have found that lay community health educator programs can be effective in changing

> worker behavior with regard to occupational safety and health.[107]

The evidence shows "worker education must focus on empowerment for collective action to remove workplace hazards"; using promotoras, lay/worker trainers and participatory methods achieves this goal.

> .. if countervailing forces in the workplace and society and the economy at large present insurmountable barriers to implementing what is learned in training, then is the training to be deemed a failure and a waste of time?[108]

Closer to home, the Alberta Workers' Health Centre borrowed from the CCCDP to develop TTT workshops for peer "brokers" to do workshops with "new Alberta workers" in first languages.

> If you present yourself as a helper and if you present yourself from the community and you have that shared lived experience, people trust it. That's when people will open up and feel safe. And that was the power of having peer-to-peer. And that takes time, that takes relationship, that takes money. It's not the same as just translating a document into some other language. It's the person who's handing over that document who becomes the crucial link. You could feel the difference in the room when the workshop was offered in first language.[109]

Newcomers: Who's coming to Manitoba/ Winnipeg? Who's working with them?

The Numbers

Manitoba is a relatively-popular province for migrants to Canada. For example, 3,400 people were moving to the province each year in the mid-1990s; three-quarters of whom were of working age.[110] Between 2011 and 2016, 41,230 people aged 15 and older arrived as immigrants in Winnipeg.[111] (This may have been partly the result of Manitoba running its own settlement services until 2013, when the federal government "repatriated" the program.)

Newcomers are a mix of refugees (government and privately sponsored), international students and visa holders, migrant workers (under the federal Temporary Foreign Workers/TFW program), and other immigrants. Table 2 shows Manitoba immigration categories and numbers for 2016 and 2017.[112]

From 2008 to 2017, 145,645 people were accepted as permanent residents in Manitoba. In 2016–17, the province was the intended destination for eight percent of newcomers using settlement services across the country.[113]

In 2017 alone, 14,700 permanent residents chose Manitoba, 5.1% of total immigration to Canada. About 80 percent arrived in Winnipeg. The top 10 languages — Tagalog, Punjabi, Chinese, English, Tigrinya, Gujarati, Russian, Arabic, Yoruba and Urdu — accounted for about 65 percent of the languages spoken amongst permanent residents that year. That year, nearly 15% of permanent residents were refugees and protected persons (2,130). Syrians represented almost 17 percent of *resettled* refugees. The remaining 83% were from Eritrea, Somalia, Iraq, Ethiopia and Democratic Republic of Congo, and many others.[114]

Only about 31 percent of the 2017 Temporary Foreign Worker (TFW) program permit holders ended up in the capital; about 71 percent of those on permits from the IMP came to Winnipeg. In contrast, most students on international study permits came to Winnipeg. countries of origin for more than 50 percent were China, India, and Nigeria.

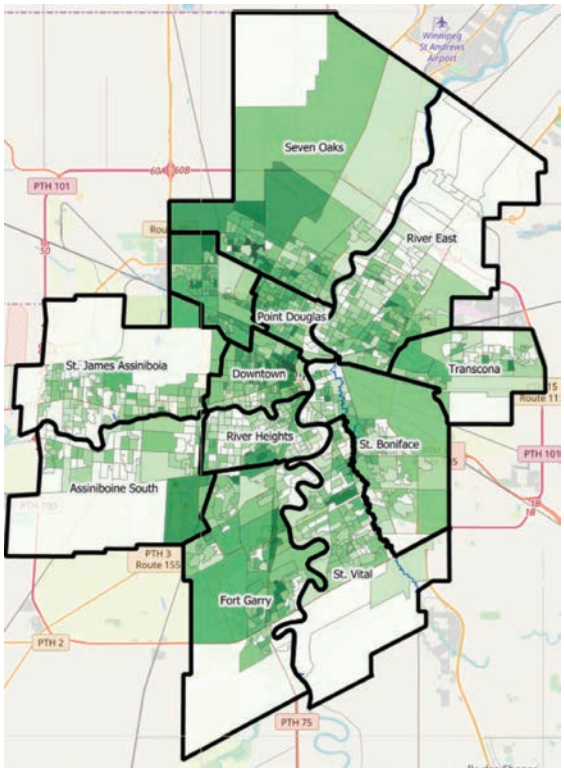
By the end of October 2019, 16,530 new permanent residents had arrived in the province since January, most of them under the Provincial Nominee Program; 1,120 arrived under the categories of "resettled refugee" or "protected person in Canada".[115] Data about new citizens by province is only available from 2012 to 2017; in the last year, Manitoba welcomed 4,789 new citizens, almost a 50 percent drop from the previous year.[116]

TABLE 2 **Manitoba Immigration Numbers, 2016–2017**

Immigration Category	2016	2017
Permanent Residents		
Sponsored Family	2,380	2,475
Skilled Workers	490	295
Provincial Nominee	9,960	9,425
Other Economic	240	330
Refugee	3,730	2,130
Other	25	35
Total Permanent Residents	**16,825**	**14,700**
Temporary Foreign Worker Program work permit holders	855	760
International Mobility Program work permit holders	6,405	6,310
International Student Study permit holders	8,595	10,440
TOTAL	**32,680**	**32,200**

SOURCE: Immigration and Economic Opportunities Division, Manitoba Education and Training (2018) Manitoba Immigration Report. Found at https://www.immigratemanitoba.com/manitoba-immigration-facts-report-2017/ - 07

FIGURE 8 **Recent Immigrants to Winnipeg. Percentage of City Population Immigrating to Canada, 2011–2016 — by Neighbourhood Cluster (2016 Census)**



SOURCE: Community Data Map, Winnipeg Health Region 2019. A product of the Manitoba Collaborative Data Portal (MBCDP), April, 2018. Found at https://mangomap.com/cgreenwpg/maps/61783/commun#

TABLE 3 **Non-Official Languages Spoken in Central Winnipeg (Downtown and Point Douglas "Neighbourhood Clusters")**

Language Spoken (top 30)	Downtown West	Downtown East	Point Douglas North	Point Douglas South	Total
Yoruba	20	40	0	0	60
Croatian	0	10	50	0	60
Gujarati	40	35	0	0	75
Dutch	30	30	15	10	85
Greek	90	20	0	0	110
Urdu	20	100	0	0	120
Hungarian	70	20	35	15	140
Hindi	25	120	10	10	165
Persian (Farsi)	0	150	15	0	165
Bengali	70	105	0	15	190
Italian	145	25	30	0	200
Punjabi (Panjabi)	140	110	25	0	275
Russian	115	115	60	40	330
Ilocano	110	110	125	10	355
Korean	100	195	40	40	375
Cebuano	165	45	100	65	375
Mandarin	145	405	0	50	600
Polish	85	145	275	140	645
Amharic	75	575	15	15	680
Ojibway	125	290	125	195	735
Tigrigna	115	685	10	10	820
Spanish	240	370	195	130	935
Arabic	255	565	80	80	980
Ukrainian	160	165	510	150	985
Somali	175	765	30	45	1015
Cantonese	315	625	125	25	1090
Vietnamese	415	270	350	55	1090
German	560	285	270	75	1190
Portuguese	710	545	240	40	1535
Tagalog (Pilipino, Filipino)	5,570	2,475	5,925	1,205	15,175
Other Languages	1,100	2,090	700	610	4500
TOTAL	**11,185**	**11,485**	**9,355**	**3,030**	**35,055**

SOURCE: City of Winnipeg (2019) *2016 Census. City of Winnipeg Neighbourhood Cluster Profiles*. Found at https://winnipeg.ca/census/2016/Clusters/default.asp. "Non-official" means besides English or French.

TABLE 4 **Languages Spoken in Winnipeg Core Area cs Overall City**

City or Neighbourhood	Total Population	Total Speaking Neither English or French	Percentage Speaking Neither English or French	Total Speaking "Non-official" Languages	Percentage Speaking "Non-official" Languages
Winnipeg	690,015	10,990	1.6	178,024	25.8
Point Douglas North	28,265	420	1.5	9,355	33.1
Point Douglas South	12,535	180	1.4	3,030	24.2
Downtown East	30,715	1,335	4.3	11,485	37.4
Downtown West	36,125	750	2.1	11,185	31.0

SOURCE: City of Winnipeg (2019) *2016 Census. City of Winnipeg Neighbourhood Cluster Profiles*. Found at https://winnipeg.ca/census/2016/Clusters/default.asp. "Non-official" means besides English or French.

Between 2011 and 2016, 52,020 people arrived in Winnipeg. These "recent immigrants" included 39,535 from Asia (the top four are 19,615 from the Philippines, 9,480 from India, 2885 from China, and 1,415 from Pakistan) and 7,100 from Africa (Nigeria had the most with 2,405, followed by Eritrea with 740). There were 13,285 "non-permanent residents",[117] which includes refugees; their arrival dates are not included in the data.[118]

Newcomers are concentrated in some areas of the city. (See the map, Figure 8.) 2016 federal census data available through the City of Winnipeg indicates there are 35,055 people in core city neighbourhoods (the four Point Douglas and Downtown "clusters") whose first language is not English or French. (About 77 percent of them — about 26,992 — are between 15 and 74, i.e., possibly in the workforce or seeking a job.)

The top six of the 30 languages tracked are Tagalog, Portuguese, German, Vietnamese, Cantonese and Somali. (See Table 3, *Non-official languages spoken in Central Winnipeg* and Table 4, *Languages spoken in Winnipeg core area vs overall city*.) Point Douglas North and Downtown have higher-than-average percentages of people speaking the "non-official" languages. 4.3 percent of Downtown East residents in the census are in the same category, compared to a city average of 1.6 percent. Point Douglas clusters are just below the average, while Downtown West is 2.1 percent.

Who's Working With Them Around Employment?

Settlement Services/Agencies

Some newcomers look to settlement services for help when they arrive. Manitoba has 12 such agencies outside Winnipeg and many within the city.

Within the capital, Manitoba Start provides centralised intake, funded by the provincial and federal governments. For many years, it has worked with Altered Minds Inc. (AMI) to offer a four-week, half-day Entry Program. The program provides settlement orientation and an introduction to the English language and services about getting around, laws, health, and employment and education. An "express" version for those with a good understanding of English can be done in one week. The agency's 20 employees come from a variety of cultural and linguistic backgrounds, speaking more than 15 languages. They provide other newcomer services. AMI's website links to 51 ethno-cultural organisations in Winnipeg, which play an important role in helping to settle newcomers.[119]

(Unfortunately, AMI heard in August, 2019, that the federal government would no longer fund them, forcing the agency to close at the end of March, 2020, unless the decision is reversed. This is despite national recognition in 2019 and a very positive 2018 evaluation by the federal funder — Immigration, Refugees, and Citizenship Canada. The Manitoba Start program may take over the Entry Program and other AMI programs.)

The Manitoba Association of Newcomer Serving Agencies (MANSO) is an umbrella organisation with 70-some members across the province. Services range from language assessment, referral and training to housing and school programs and employment supports. It holds professional development events (22 in 2018–2019) for member agencies and others, including one by the MFL OHC. The Centre is a MANSO member (the only one considered to be an OHS resource), and the OHC's Community Development Worker is on its Health Committee, which currently focuses on disability and mental health.[120]

MANSO also is a member of a national settlement community of practice, SettlementNet.org, the Canadian Immigrant Settlement Sector Alliance-Alliance canadienne du secteur de l'établissement des immigrants (CISSA-ACSEI), the Canadian Council for Refugees, the IRCC's policy and programme National Settlement Council, Immigration Research West, and local immigration partnerships, including Immigration Partnership Winnipeg (IPW), housed at the Winnipeg Social Planning Council.

The IPW's 2016–2020 strategic priorities include "Support the creation or expansion of progressive policies and practices that improve newcomer employment outcomes through stable and meaningful employment." However, it does not include anything about workers' rights or occupational health and safety, or enlightening employers about these topics.[121] Its website employment services page includes links to the provincial government, four ethno-cultural organisations, four community development organisations and Manitoba Start.[122]

Who's Working With Them Around Health And Safety? Government Services/Agencies

The numbers of "recent immigrants" — especially those who might join the workforce — and languages spoken have serious implications for relatively-complex topics such as workers' rights, health and safety laws, and workers' compensation "rules". Providing English-only materials and websites to reach workers and employers effectively denies many newcomers and new citizens access to information they need and are supposed to get. Yet some variation of that situation faces many Manitoba newcomers.

The Manitoba Workers' Compensation Board (WCB) and SAFE Work Manitoba have responded recently to newcomers' needs with multilingual materials.

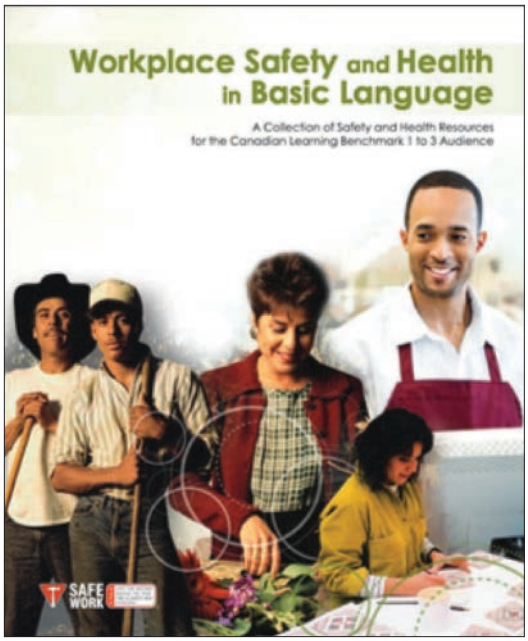
At the WCB, basic worker information is available on-line in English, French, German, Spanish, Mandarin, Tagalog, Punjabi and Russian, although the links on the front page are not obvious. This means that Vietnamese, Amharic, Somali, Cantonese, and Portuguese speakers — whose languages are more common amongst Manitoba newcomers than some of those used — may not (easily) find information in their mother tongues.

SAFE Work Manitoba is responsible for health and safety consultations and information. It has resources about workers' rights and employers' responsibilities for training and orientation in 19 languages (English, French, Arabic, Chinese, Cree, German, Greek, Italian, Korean, Ojibwe, Polish, Portuguese, Punjabi, Russian, Spanish, Tagalog, Tamil, Ukrainian and Vietnamese). However, the links are difficult to find in small print at the very bottom of the English website, not on the header tabs. Some materials are labelled with their English-language names, making it very difficult for those speaking other languages to determine the topic.[123]

For several years, SAFE Work Manitoba has had a campaign called *Safety is a language we can all speak*. With videos in several languages and "featured multi-language resources" (e.g., a Tip Card about employers' and workers' responsibilities, a bulletin about workers' rights and responsibilities), the site has obvious links to materials in a variety of languages (19, including English). However, on the individual pages, the links are much smaller, diminishing their

importance and accessibility. The documents themselves are not the most user-friendly (e.g., the column width makes them difficult to read, graphics are few and far between).

The agency has worked with others to produce materials. A project with the Immigrant Centre Manitoba led to *Being safe at work guide*, designed for newcomers. Available only in English, it uses relatively clear language while perpetuating the inaccurate statement that "workers and employers share responsibility for safety at work" (see page 8). It does explain workers' four OHS rights, and provides examples of injuries and hazards, while regularly using the word "safety". This distorted picture about hazards and their effects leaves out health (almost always) and does not use "sick", "disease" or "illness".

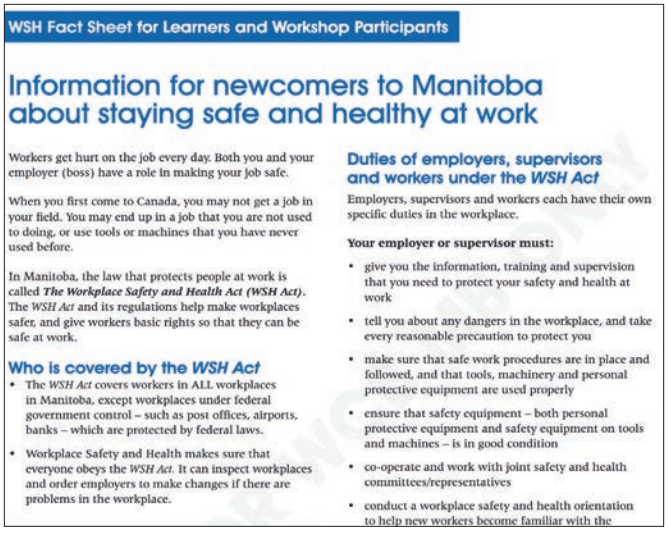


SAFE Work Manitoba also was part of a Safety Services Manitoba project funded by the WCB in 2006, the Manitoba Immigrant Safety Initiative (MISI).[124] With the Adult Language Training staff in Manitoba Labour and Immigration's Immigration, Settlement and Multiculturalism Division, the project produced *Workplace safety and health in basic language. A collection of safety and health resources for the Canadian learning benchmark 1 to 3 audience*. It does not mention unions, the MFL Occupational Health Centre or workers' rights. (The fact sheets in other languages produced by the MISI project are not readily obvious on the Safe Work site.)

The related *Health and Safety 101* is still on the ImmigrateManitoba.com website, run by the provincial government. The document was designed to go with an on-line program of the same name. It was prepared "to help EAL instructors and safety trainers prepare newcomers to fully understand the safety and health training they receive in the workplace," so they can follow the *Health and Safety 101* on-line training program. There was no evidence of the program — adapted for Manitoba by government and WCB staff in the early 2000s and based on an Ontario Workers' Safety Insurance Board/WSIB site — on-line.

Interestingly, the *Health and Safety 101* link is buried deeply, under Resources for English language instructors (not employers) in the Information for Community section of the government site. The document does mention OHC fact sheets but not the CCCDP, which had been going for several years at that point. Other resources for newcomer workers and their employers there include:

- *Workplace Safety and Health – Basic Language Guide*
- *Prevention is the Best Medicine: A Toolkit for Newcomers to Manitoba*
- *The Incident* (video) — based on a true story of what happened to a female newcomer whose fingers were damaged while using



WSH Fact Sheet for Learners and Workshop Participants

Information for newcomers to Manitoba about staying safe and healthy at work

Workers get hurt on the job every day. Both you and your employer (boss) have a role in making your job safe.

When you first come to Canada, you may not get a job in your field. You may end up in a job that you are not used to doing, or use tools or machines that you have never used before.

In Manitoba, the law that protects people at work is called ***The Workplace Safety and Health Act (WSH Act)***. The *WSH Act* and its regulations help make workplaces safer, and give workers basic rights so that they can be safe at work.

Who is covered by the *WSH Act*

- The *WSH Act* covers workers in ALL workplaces in Manitoba, except workplaces under federal government control – such as post offices, airports, banks – which are protected by federal laws.
- Workplace Safety and Health makes sure that everyone obeys the *WSH Act*. It can inspect workplaces and order employers to make changes if there are problems in the workplace.

Duties of employers, supervisors and workers under the *WSH Act*

Employers, supervisors and workers each have their own specific duties in the workplace.

Your employer or supervisor must:

- give you the information, training and supervision that you need to protect your safety and health at work
- tell you about any dangers in the workplace, and take every reasonable precaution to protect you
- make sure that safe work procedures are in place and followed, and that tools, machinery and personal protective equipment are used properly
- ensure that safety equipment – both personal protective equipment and safety equipment on tools and machines – is in good condition
- co-operate and work with joint safety and health committees/representatives
- conduct a workplace safety and health orientation to help new workers become familiar with the

Prevention is the best medicine. Fact sheet for learners (about health and safety). From: https://www.wcb.mb.ca/sites/default/files/files/2573%20WCB%20IWH%20WHS%20Fact%20Sheet%20for%20Learners1.pdf

> a machine for which she had no training, fearing repercussions for speaking up, and how to use the right to refuse and file claims.

The MASI project also produced *A Safe Immigrant Workforce for Manitoba: An Employer's Guide for Health and Safety Training* and a wallet card, postcard and poster about multilingual rights and responsibilities for immigrant workers and their employers, in French, German, Mandarin, Punjabi, Russian, Spanish and Tagalog.[125] However, the guide and material are not available on the SAFE Work Manitoba website.

About the same time, Prairie Research Associates produced *Analysis of the language, cultural and literacy needs of WCB clients* for the Board. According to the 2009 RWIP annual report, the $124,906 project, awarded in 2007

> established that some WCB clients face barriers due to language, culture or literacy in communicating with the WCB. Language barriers emerged as a more important issue than cultural or literacy barriers. Clients who face a barrier in one dimension are more likely to experience barriers in others. The study identified that multiple overlapping barriers complicate the distinctive factors that impact communication between the WCB and its immigrant clients. The results of this study will enable the WCB to develop strategies that will address the needs of newcomer and immigrant workers and employers in Manitoba.[126]

In 2011, the Toronto-based Institute for Work and Health (IWH) produced a toolkit for newcomers, *Prevention is the best medicine.* It was based on research done by IWH staff, looking at health and safety and workers' compensation issues facing newcomers in Ontario. Two years later, the Manitoba WCB and the Workplace Safety and Health Branch adapted it for Manitoba. Available on the WCB website (but not on the SAFE Work Manitoba one, where it is supposed to be too), it has fact sheets for learners and teachers' lesson plans are all in English.

The Workplace Safety and Health Branch enforces the *Workplace Safety and Health Act*. Once the Department of Environment and Workplace Safety and Health, it now is part of the provincial Finance Department's Labour & Regulatory Services.

The Branch "targets high-risk hazards and sectors, as well as repeated or willful non-compliance". Its safety and health officers can issue improvement or stop work orders, requiring employers to fix job-related hazards; they also can issue administrative penalties, up to $5,000, for "wilful, severe, or repeated non-compliance".[127] Its website is available only in French or English. There is no indication that Branch staff can speak particular languages or offer translation for calls about refusals, or other issues.[128]

Endnotes

1 Migrant is a general term that does not distinguish the status of people who have come to Canada. OHC defines "newcomers" as the broad range of permanent residents, refugees, refugee claimants, migrant workers/temporary foreign workers(TFWS), new Canadian citizens, international students and undocumented migrants in Canada. The federal government's Immigration Refugees & Citizenship Canada (IRCC) restricts funding to programs for permanent residents and refugees. OHC has used other funding sources to do work with other types of newcomers (e.g., migrant workers). This report uses the OHC definition, and alternates between "newcomer" and "migrant" to emphasise the definition.

2 Barnetson, Robert (2013) *Political economy of workplace injury in Canada*, AU Press (Athabasca University). Found at http://aupress.ca/index.php/books/120178.

3 An "accident" is an unanticipated event — sometimes with dire consequences — that could not be prevented. Since health and safety hazards can be prevented, the term is inaccurate. (The current SAFE Work Manitoba campaign: *Safe workers aren't born, they're trained. Sending a worker to do a job without training is like sending a young child to do that same job* makes this clear.) It implies the harm could not be avoided. "Incident" is one alternative. The word "accident" often is linked to using the phrase "careless workers" to explain incidents, even though studies make it clear hazards are the real issue. Finally, the term is said to have been deliberately introduced with early workers' compensation laws, to alleviate employers' responsibilities for working conditions.

4 Barnetson, Robert (2013) *Political economy of workplace injury in Canada*, AU Press (Athabasca University). Found at http://aupress.ca/index.php/books/120178.

5 Wigmore, Dorothy (2005) "A common goal: Union and researcher collaboration celebrate the work of June Fisher, M.D.", *New Solutions*, 15 (1): 3–14. Also see the 1978 NFB film, *Our health is not for sale.* The authoritative source of information about the IWM is: Ivar Iddone (Ed.) (1969) *L'ambiente di lavoro*, FIOM-CGIL. An English source of information about the IWM is Misiti, R., & Bagnara, S. (1985) "Participation in health control at the workplace: the Italian experience", in: Bagnara, S., Misiti,, R., & Wintersberger, H., (Eds.) *Work and Health in the 1980s. Experiences of direct workers' participation in occupational health*, pp. 31–106.

6 Smith, Doug (2000) *Consulted to death. How Canada's workplace health and safety system fails workers*, Arbeiter Ring, Winnipeg, p. 43.

7 United Nations Human Rights Council (2019) *Principles on human rights and the protection of workers from exposure to toxic substances. Report of the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes*. Found at https://digitallibrary.un.org/record/3823886.

8 Levy, B. & Wegman, D., Editors. (2000) *Occupational Health. Recognizing and preventing work-related disease and injury. 4th Edition*.

9 Stoffman, L., Thorpe, B. & Wigmore, D. (2015) *Tools for informed substitution. How do you find safer chemicals*

for the workplace? Found at https://www.wigmorising.ca/cleaning-products-can-be-green/.

10 Tompa, E., Trevithick, S. & McLeod, C. (2004) *A systematic review of Stakeholder Engagement for Chemicals Management in Canada*, Institute for Work & Health, Working Paper #213. Also see the findings about awareness in the updated study in Tompa, E., et. al., (2016) "A systematic literature review of the effectiveness of occupational health and safety regulatory enforcement", *American Journal of Industrial Medicine*, 59: 919–933.

11 International Standards Organisation/ISO (2018) *ISO 45001:2018 Occupational health and safety management systems — Requirements with guidance for use*. Found at https://www.iso.org/standard/63787.html.

12 Canadian Standards Association/CSA (2019) CSA Z45001:19. *Occupational health and safety management systems — Requirements with guidance for use (Adopted ISO 45001:2018, first edition, 2018–03, with Canadian deviations)*. Found at https://store.csagroup.org/ccrz__ProductDetails?viewState=DetailView&cartID=&portalUser=&store=&cclcl=en_US&sku=CSA%20Z45001%3A19.

13 It is important to note the difference between "hazard" — the inherent properties of something to cause harm — and "risk" — the odds of that happening. A hazard-based approach is the public health one, because it leads to solutions like "green chemistry" (recipes for non-toxic or much less toxic chemicals/products) and effective stress-reducing work organisation. Focussing on risk leads to debates about costs, who is affected, what counts as an effect, etc., and delays finding primary prevention while people and/or the environment pay the price. For more about the consequences, see the European Environment Agency's reports, *Late lessons from early warnings* at https://www.eea.europa.eu/publications/environmental_issue_report_2001_22 and https://www.eea.europa.eu/publications/late-lessons-2.

14 Penney, J. (1991) "Negotiating Ontario standards", *New Solutions*, 2(2): 9 – 14.

15 World Health Organization (2008) *Commission on social determinants of health — final report: Closing the gap in a generation: Health equity through action on the social determinants of health.* Found at https://www.who.int/social_determinants/thecommission/finalreport/en/.

16 International Labour Organisation. *Decent work*. Found at https://www.ilo.org/global/topics/decent-work/lang--en/index.htm.

17 Baron, S.L., et. al. (2014) "Promoting integrated approaches to reducing health inequities among low-income workers: Applying a social ecological framework", *American Journal of Industrial Medicine*, 57(5): 539–556.

18 Kickbusch, I., Allen, L. & Franz, C. (2016) "The commercial determinants of health", *The Lancet*, 4: e895–896.

19 Jahiel, R.I. (2008) "Corporation-induced diseases, upstream epidemiologic surveillance, and urban health", *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 85 (4): 517–531.

20 Millar, John S. (2013) "The corporate determinants of health: How big business affects our health, and the need for government action!", *Canadian Journal of Public Health*, 104 (4): e327-e329.

21 Michaels, David (2008) *Doubt is their product. How industry's assault on science threatens your health*, Oxford University Press. In 2020, the same publisher is releasing *The triumph of doubt. Dark money and the science of deception*. See https://www.drdavidmichaels.com/books.

22 Abrams, Herbert K. (2001) "A short history of occupational health", *Journal of Public Health Policy*, 22 (1): 34–80; Kriebel, D. (2007) "The reactionary principle: Inaction for public health", *Occupational and Environmental Medicine*, 64 (9): 574–574; Natural Resources Defense Council (2011) *How the chemical industry ducks regulation of the most toxic substances*. Found at https://www.nrdc.org/resources/chemical-industry-delay-game; and Union of Concerned Scientists (2015) *Bad chemistry: How the chemical industry's trade association undermines the policies that protect us*. Found at https://www.ucsusa.org/sites/default/files/attach/2015/07/ucs-american-chemistry-council-report-2015.pdf.

23 Knai, C., et. al. (2018) "Systems thinking as a framework for analyzing commercial determinants of health" *The Milbank Quarterly*, 96 (3): 472–498.

24 McKee, M. & Stuckler, D. (2018) "Revisiting the corporate and commercial determinants of health", *American Journal of Public Health*, 108: 1167–1170.

25 Dawes, Daniel E. (2020) *The political determinants of health*, John Hopkins University Press. See https://jhupbooks.press.jhu.edu/title/political-determinants-health

26 Mishori, Ranit. (2019) "The social determinants of health? Time to focus on the political determinants of health!", *Medical Care*, 57 (7): 491–493.

27 Smith, Doug (2000) *Consulted to death. How Canada's workplace health and safety system fails workers*. ARP Books, Winnipeg; Sass, Robert, presentation at the Global Workplace: Challenges and Strategies for Occupational Health and Safety Conference, Alberta Workers' Health

Centre, Calgary, Alberta, October 7–10, 2004, in the author's personal collection.

28 Richardson, C. (2006) *Treat it as continuous bargaining.* Found at http://charleyrichardson.org/wp-content/uploads/ContBarg-4-072.pdf.

29 Barnetson, Robert (2013) *Political economy of workplace injury in Canada*, AU Press (Athabasca University). Found at http://aupress.ca/index.php/books/120178.

30 Barnetson, Robert (2013) *Political economy of workplace injury in Canada*, AU Press (Athabasca University). Found at http://aupress.ca/index.php/books/120178; Smith, D. (2000) *Consulted to death. How Canada's workplace health and safety system fails workers*. ARP Books, Winnipeg.

31 Sass, Robert (1987) "Alternative policies in the administration of occupational health and safety programs", *Economic and Industrial Democracy*, 8: 243–257.

32 Sass, Robert (1987) "Alternative policies in the administration of occupational health and safety programs", *Economic and Industrial Democracy*, 8: 243–257.

33 Deutsch, S. (1981) "Work environment reform and industrial democracy", *Sociology of Work And Occupations*, 8 (2): 180–194.

34 Granzow, K. & Theberge, N. (2009) "On the line: Worker democracy and the struggle over occupational health and safety", *Qualitative Health Research*, 19 (1): 82–93.

35 For example, Institute for Work & Health, *Participatory ergonomics*. Found at https://www.iwh.on.ca/topics/participatory-ergonomics; and Burgess-Limerick, Robin (2018) "Participatory ergonomics: Evidence and implementation lessons", *Applied Ergonomics*, 68: 289–293.

36 Malchaire, J. (2004) "The SOBANE risk management strategy and the Déparis method for the participatory screening of the risks", *International Archives of Occupational and Environmental Health*, 77 (6): 443 – 450.

37 Canadian Standards Association/CSA (2019) CSA Z45001:19. *Occupational health and safety management systems — Requirements with guidance for use (Adopted ISO 45001:2018, first edition, 2018–03, with Canadian deviations).* Found at https://store.csagroup.org/ccrz__ProductDetails?viewState=DetailView&cartID=&portalUser=&store=&cclcl=en_US&sku=CSA%20Z45001%3A19.

38 For one explanation, see the Canadian Centre for Occupational Health and Safety's version at https://www.ccohs.ca/oshanswers/legisl/irs.html.

39 Barnetson, Robert (2013) *Political economy of workplace injury in Canada*, AU Press (Athabasca University). Found at http://aupress.ca/index.php/books/120178.

40 Government of Ontario (1976) *Report of the Royal Commission on the Health and Safety of Workers in Mines*, Toronto, Ministry of the Attorney General, Commissioner James M. Ham. Found at https://archive.org/details/reportofroyworkmineooonta.

41 SAFE Work Manitoba, *Workplace Safety and Health Committee Member.* Found at https://www.safemanitoba.com/Roles/Pages/Workplace-Safety-and-Health-Committee-Member.aspx.

42 Smith, Doug. (2000) *Consulted to death. How Canada's workplace health and safety system fails workers*. ARP Books, Winnipeg.

43 For one example of the acknowledgement about different interests, power and conflict, see the "Committee Process Toolkit" in the Manitoba WCB-funded, SAFE Work Manitoba-approved *Seeing the workplace with new eyes. A self-help guide for workplace safety and health committees and workplace safety and health representatives.* Found at https://www.wigmorising.ca/wp-content/uploads/2018/05/new-eyes-j-committee-process-toolbox.pdf.

44 Alberta Workers' Health Centre (2017) *New Alberta Workers. Improving workplace health and safety for temporary foreign workers and other new to Alberta workers*. Found at https://workershealthcentre.ca/new-alberta-workers/.

45 *Report of the Advisory Council on Workplace Safety and Health 2017 Review of the Workplace Safety and Health Act, December 31, 2017.*

46 Personal communications with two of the law's authors at different points in time.

47 *Report of the Advisory Council on Workplace Safety and Health 2017 Review of the Workplace Safety and Health Act, December 31, 2017.*

48 *Report of the Advisory Council on Workplace Safety and Health 2017 Review of the Workplace Safety and Health Act, December 31, 2017.*

49 Hall, A., Forrest, A., Sears, A. & Carlan, N., (2006) "Making a difference. Knowledge activism and worker representation in joint OHS committees"; and Labour OHCOW Academic Research Collaboration/LOARC (2014) *Health and safety representation. Writing the workers back in*. Found at https://www.ona.org/wp-content/uploads/loarc_workersguide_201404.pdf.

50 United Nations Human Rights Council (2019) *Principles on human rights and the protection of workers from exposure to toxic substances. Report of the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous*

substances and wastes. Found at https://digitallibrary.un.org/record/3823886.

51 Smith, Doug (2008) *A history of the occupational safety and health movement in Manitoba*, Second edition. Manitoba Federation of Labour Occupational Health Centre; Barnetson, Robert (2013) *Political economy of workplace injury in Canada*, AU Press (Athabasca University). Found at http://aupress.ca/index.php/books/120178; and Storey, Robert (2004) "From the Environment to the Workplace . . . and Back Again? Occupational Health and Safety Activism in Ontario, 1970s-2000+", *Canadian Review of Sociology and Anthropology*, 41 (4): 419–447.

52 Annable, Kristen (2017) *Province axes workplace safety committee, affected groups raise concerns.* Found at https://www.cbc.ca/news/canada/manitoba/workplace-safety-legislation-pallister-1.4442000.

53 The *Act* defines new workers in section 2.2.1(1) as not just those new to the workplace but people who have done different tasks elsewhere in the workplace, come from another workplace with different processes or hazards, or are returning to a job where the processes and/or hazards have changed in their absence.

54 SAFE Work Manitoba (2014) *Safety and health orientation requirements.* Found at https://www.safemanitoba.com/Page%20Related%20Documents/resources/bltn_255_swmb_dec_2014.pdf.

55 SAFE Work Manitoba (2019) *The Manitoba Workplace Injury Statistics Report 2009–2018.* Found at https://www.safemanitoba.com/Page%20Related%20Documents/resources/Manitoba%20Workplace%20Injury%20Statistics%20Report%202009-2018_SWMB.pdf.

56 Tucker, S. & Keefe, A. (2019) *2019 report on work fatality and injury rates in Canada.* Found at https://www.uregina.ca/business/faculty-staff/faculty/file_download/2019-Report-on-Workplace-Fatalities-and-Injuries.pdf.

57 Institute for Work & Health (2019) "Progress seen in occupational disease prevention, but data still lacking: speaker", *At Work 95*. Found at https://www.iwh.on.ca/newsletters/at-work/95/progress-seen-in-occupational-disease-prevention-but-data-still-lacking-speaker.

58 Bittle, S., Chen, A., & Hébert, J. (2018) "Work-related deaths in Canada" *Labour/Le Travail*, 82:159–187.

59 For example, stressors have consistently been linked to musculoskeletal disorders/injuries in the neck, shoulders and lower back since initial studies of male Finnish paper workers in the early 1990s.

60 Barnetson, Robert (2013) *Political economy of workplace injury in Canada*, AU Press (Athabasca University). Found at http://aupress.ca/index.php/books/120178.

61 Racialisation is a social process that describes some groups as different because of characteristics like physical traits, culture or place of birth; the result is less access to social, economic and political resources, according to Premji, S. & Lewchuk, W. (2014) "Racialised and gendered disparities in occupational exposures among Chinese and white workers in Toronto", *Ethnicity & Health*, 19 (5): 512–528, citing Galabuzi (2006).

62 Law Commission of Ontario (2012) *Vulnerable workers and precarious work. Final report.* Found at https://www.lco-cdo.org/wp-content/uploads/2013/03/vulnerable-workers-final-report.pdf.

63 Smith, P. & Mustard, C. (2009) "Comparing the risk of work related injuries between immigrants to Canada, and Canadian-born labour market participants", *Occupational and Environmental Medicine*, 66 (6): 361–367.

64 Lay, M. et. al. (2017) "The relationship between occupational health and safety vulnerability and workplace injury", *Safety Science*, 94: 85- 93.

65 Premji, S., Duguay, P., Messing, K. & Lippel, K. (2010) "Are immigrants, ethnic and linguistic minorities overrepresented in jobs with a high level of compensated risk? Results from a Montreal, Canada study using census and workers' compensation data", *American Journal of Industrial Medicine*, 53 (9): 875–885; Premji, S., Messing, K. & Lippel, K. (2008) "Broken English, broken bones? Mechanisms linking language proficiency and occupational health in a Montreal garment factory", *International Journal of Health Services,* 38 (1): 1–19; and Smith P.M., Kosny A.A. & Mustard, C.A. (2009) "Differences in access to wage replacement benefits for absences due to work-related injury or illness in Canada", *American Journal of Industrial Medicine*, 52 (4): 341–49.

66 Kosny, A., et. al. (2011) *Delicate dances: Immigrant workers' experiences of injury reporting and claim filing.* Toronto: Institute for Work & Health. Found at https://www.iwh.on.ca/scientific-reports/delicate-dances-new-immigrants-experiences-after-work-related-injury.

67 Kosny, A. & Lifshen M. (2011) *Review of safety resources for recent immigrants entering the Canadian workforce.* Toronto: Institute for Work & Health. Found at https://www.iwh.on.ca/scientific-reports/review-of-safety-resources-for-recent-immigrants-entering-canadian-workforce.

68 Institute for Work & Health (2016) *Vulnerable workers and risk of injury.* Found at https://oldiwh.iwh.on.ca/system/files/documents/vulnerable_workers_ib_-_nov-2016-final.pdf.

69 Kazi, M.R., et. al. (2019) "Injury among the immigrant population in Canada: exploring the research landscape

through a systematic scoping review", *International Health*, 11: 203–214.

70 Kosny, A., et. al. (2019) "Safe employment integration of recent immigrants and refugees", *Journal of International Migration and Integration*, https://doi.org/10.1007/s12134-019-00685-w.

71 Smith, P.M., & Mustard, C.A. (2010) "The unequal distribution of occupational health and safety risks among immigrants to Canada compared to Canadian-born labour market participants: 1993–2005", *Safety Science*, 48: 1296–1303.

72 Yanar, B., Kosny, A., & Smith, P.M. (2018) "Occupational health and safety vulnerability of recent immigrants and refugees", *International Journal of Environmental Research and Public Health*, 15, 2004. Found at https://www.mdpi.com/1660-4601/15/9/2004.

73 MFL Occupational Health Centre. S*pirit Tool Kit*. Found at http://mflohc.mb.ca/healthy-workplace-practices/spirit-tool-kit/.

74 Kosny, A., et. al. (2019) "Safe employment integration of recent immigrants and refugees", *Journal of International Migration and Integration*, https://doi.org/10.1007/s12134-019-00685-w

75 Kosny, A., et. al. (2019) "Safe employment integration of recent immigrants and refugees", *Journal of International Migration and Integration*, https://doi.org/10.1007/s12134-019-00685-w

76 Jackson, Andrew (2017) *The reality of racial discrimination underlined in new Census Data*. Found at https://www.broadbentinstitute.ca/andrew_ajackson/the_reality_of_racial_discrimination_underlined_in_new_census_data.

77 Ng, W., et. al. (2016) *'Working so hard and still so poor!' A public health crisis in the making: The health impacts of precarious work on racialized refugee and immigrant women*. Found at https://www.ryerson.ca/socialjustice/media-events/2016/10/working-so-hard-and-still-so-poor/.

78 Senthanar, S., MacEachen, E., Premji, S. & Bigelow, P. (2019) "'Can someone help me?' Refugee women's experiences of using settlement agencies to find work in Canada", *Journal of International Migration and Integration*, In press.

79 Premji, S. & Shakya, Y. (2017) "Pathways between under/unemployment and health among racialized immigrant women in Toronto", *Ethnicity & Health*, 22: 17–35.

80 Institute for Work & Health (2016) *Ontario prevention system adopts IWH conceptual framework for OHS vulnerability*. Found at https://www.iwh.on.ca/impact-case-studies/ontario-prevention-system-adopts-iwh-conceptual-framework-for-ohs-vulnerability.

81 Smith, P., et. al. (2015) "The development of a conceptual model and self-reported measure of occupational health and safety vulnerability", *Accident Analysis and Prevention*, 82: 234–243.

82 Yanar, B., Kosny, A., & Smith, P.M. (2018) "Occupational health and safety vulnerability of recent immigrants and refugees", *International Journal of Environmental Research and Public Health*, 15, 2004. Found at https://www.mdpi.com/1660-4601/15/9/2004.

83 Yanar, B., Kosny, A., & Smith, P.M. (2018) "Occupational health and safety vulnerability of recent immigrants and refugees", *International Journal of Environmental Research and Public Health*, 15, 2004. Found at https://www.mdpi.com/1660-4601/15/9/2004.

84 Smith, Peter (2019) Personal communication, December 19.

85 Howse, D. (2019) "'You can't solve precarity with precarity.' The New Alberta Workers Program: An interview with Jared Matsunaga-Turnbull, Executive Director of the Alberta Workers' Health Centre", *New Solutions*, 29 (3): 459–477.

86 Lerner, Michael (1986) *Surplus Powerlessness: The psychodynamics of everyday life and the psychology of individual and social transformation*, Institute for Labor & Mental Health, Oakland, California.

87 The information in this section is drawn from the author's knowledge and the second edition of Doug Smith's *An injury to all. A history of the occupational safety and health movement in Manitoba*.

88 Smith, Doug (2008) *An injury to all. A history of the occupational safety and health movement in Manitoba*, Second edition. Manitoba Federation of Labour Occupational Health Centre.

89 See the OHC website at www.mflohc.mb.ca.

90 See https://workershealthcentre.ca/.

91 See https://www.ohcow.on.ca/.

92 MFL Occupational Health Centre (2019) *Annual Report 2018–2019*. Found at http://mflohc.mb.ca/wp-content/uploads/2019/07/Annual-Report_2019.pdf.

93 World Health Organisation (1986) *The Ottawa Charter for Health Promotion*. Found at https://www.who.int/health-promotion/conferences/previous/ottawa/en/index1.html.

94 Labonte, R. & Laverack, G. (2001) "Capacity building in health promotion, Part 1: for whom? And for what purpose?" *Critical Public Health*, 11 (2): 111–127.

95 Kuyek, Joan (1990) *Fighting for hope. Organizing to realize our dreams*, Black Rose Books, Montreal; Labonte, R. (1999) "Health promotion in the near future: remem-

brances of activism past", *Health Education Journal*, 58: 368–377; Labonte, R. & Laverack, G. (2001) "Capacity building in health promotion, Part 1: for whom? And for what purpose?", *Critical Public Health*, 11 (2): 111–127; Laverack, G. & Keshavarz Mohammadi, N. (2011) "What remains for the future: strengthening community actions to become an integral part of health promotion practice", *Health Promotion International*, 26 (S2): ii258–ii262.

96 Arnstein, Sherry (2019) "A ladder of citizen participation", *Journal of the American Planning Association*, 85 (1): 24–34 (reprinted from the original 1969 article).

97 Cornwall, Andrea (2008) "Unpacking 'Participation': models, meanings and practices", *Community Development Journal*, 43 (3): 269–283.

98 Baron, Sherry (2014) "Promoting integrated approaches to reducing health inequities among low-income workers: Applying a social ecological framework", *American Journal of Industrial Medicine*, 57 (5): 539–556.

99 Labour Education Centre (2009) *Integrating Equity, Addressing Barriers: Innovative Learning Practices by Unions*, 2nd edition. Toronto. Found at https://learninginsolidarity.ca/wp-content/uploads/2013/12/integrating_equity_Labour-Ed-Centre_2009.pdf.

100 For example, the author has delivered OHS train-the-trainer workshops to UFCW 832 members and members of joint health and safety committees in the Manitoba health care sector.

101 Toronto and York Region Labour Council. *Manuals and guides.* Found at https://www.labourcouncil.ca/manuals_guides.

102 Torres, S., et. al. (2014) "Improving health equity: The promising role of community health workers in Canada", *Healthcare Policy,* 10 (1): 73–85.

103 See http://www.yorku.ca/ine/.

104 *Immigrants and Precarious Employment A Popular Education Workshop*. 2009. Found at http://www.yorku.ca/ine/docs/may_2009/Immigrants_and_Precarious_Work_Participant_Kit.pdf.

105 Schurman, S., Silverstein, B.A. & Richards, S. E. (1994) "Designing a curriculum for healthy work: Reflections on the United Automobile, Aerospace and Agricultural Implement Workers-General Motors ergonomics pilot project", *Occupational Medicine*, 9 (2):283–304.

106 Forst, L., et.al. "More than training: Community-based participatory research to reduce injuries among Hispanic construction workers", (2013) *American Journal of Industrial Medicine*, 56 (8): 827–37.

107 Bush, D., et al. (2014) "Evaluation of a pilot promotora program for Latino forest workers in southern Oregon", *American Journal of Industrial Medicine,* 57 (7): 788–99.

108 Weinstock, D. & Slatin, C. (2012) "Learning to take action: The goals of health and safety training", *New Solutions*, 22 (3): 255–67.

109 Howse, Dana (2019) "'You can't solve precarity with precarity.' The New Alberta Workers Program: An interview with Jared Matsunaga-Turnbull, Executive Director of the Alberta Workers' Health Centre", *New Solutions,* 29 (3): 459–477.

110 Smith, Doug (2008) *A history of the occupational safety and health movement in Manitoba*, Second edition. Manitoba Federation of Labour Occupational Health Centre.

111 Statistics Canada, 2016 *Census data tables*. Found at https://bit.ly/2ExzWah

112 Immigration and Economic Opportunities Division, Manitoba Education and Training (2018) *Manitoba Immigration Report*. Found at https://www.immigratemanitoba.com/manitoba-immigration-facts-report-2017/ - 07.

113 Immigration, Refugees and Citizenship Canada (2017) *Evaluation of the settlement program*. Found at https://www.canada.ca/content/dam/ircc/documents/pdf/english/evaluation/e2-2016-settlementen.pdf.

114 Government of Manitoba, *Manitoba Immigration Facts Report 2017*. Found at https://www.immigratemanitoba.com/manitoba-immigration-facts-report-2017/.

115 Immigration, Refugees and Citizenship Canada (2019) *Canada – Admissions of permanent residents by province/territory of intended destination and immigration category, January 2015–October 2019*. Found at http://www.cic.gc.ca/opendata-donneesouvertes/data/IRCC_M_PRadmiss_0001_E.xls.

116 Immigration, Refugees and Citizenship Canada (2018) *New citizens by province or territory of residence (in persons)*. Found at http://www.cic.gc.ca/opendata-donneesouvertes/data/IRCC_citz_0003_E.xls.

117 Defined by Statistics Canada as "persons from another country who have a work or study permit or who are refugee claimants, and their family members sharing the same permit and living in Canada with them". Found at https://www12.statcan.gc.ca/census-recensement/2016/ref/guides/007/98-500-x2016007-eng.cfm.

118 Statistics Canada (2017) *Winnipeg, CY [Census subdivision], Manitoba and Canada [Country]* (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017.

Found at https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E.

119 Found at https://alteredminds.ca/ethnocultural-organisations/.

120 MANSO (2019) *2018–2019 Annual report*. Found at https://mansomanitoba.ca/wp-content/uploads/2019/06/MANSO-Annual-Report-EN.pdf.

121 Immigration Partnership Winnipeg (2016) *2016–20 Strategic Plan Report*. Found at https://f65d7c05-953a-49f9-a817-2bc7c281208c.filesusr.com/ugd/cc8458_5a6ac8d7477b4cd8a3a33169b0a9e3b8.pdf.

122 See https://www.ipwinnipeg.org/all.

123 For example, see the Portuguese materials at https://www.safemanitoba.com/Language/Pages/Portuguese.aspx, where Tip card: Cold-stress and Resolving safety and health concerns are both labelled in English.

124 Workers' Compensation Board (2010) *Research and Workplace Innovation Program 2009 Annual report*. Found at https://www.wcb.mb.ca/sites/default/files/files/1889%20RWIP%20Report_LR.pdf.

125 Workers' Compensation Board (2010) *Research and Workplace Innovation Program 2009 Annual report*. Found at https://www.wcb.mb.ca/sites/default/files/files/1889%20RWIP%20Report_LR.pdf.

126 Workers' Compensation Board (2010) *Research and Workplace Innovation Program 2009 Annual report*. Found at https://www.wcb.mb.ca/sites/default/files/files/1889%20RWIP%20Report_LR.pdf.

127 Workplace Safety and Health. Found at https://www.gov.mb.ca/labour/safety/.

128 For example, see the Portuguese *Seu direito de recusar trabalhos perigosos* hand-out, which tells people they can call the Branch 24 hours a day to report a refusal.

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