National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

Niagara Region adapts their COVID-19 response to prioritize Seasonal Agricultural Workers

The Niagara region, located in Ontario, has a sizable seasonal agricultural worker population, with an estimated 3,000 workers arriving each farming season. These workers often face barriers to health care in Canada due to language, fear, stigma, and cultural barriers. When the first COVID-19 case was identified in this population, NRPH&ES knew they needed to respond rapidly through a tailored approach that was based on trust and equity.

The first case of COVID-19 in seasonal workers in the Niagara region came from the Hamilton region hospital. NRPH got a call saying, "Can you help us do contact tracing? We need someone who speaks Spanish." Fortunately, we had staff that could speak Spanish and could support this request. This interaction marked the beginning of a public health response centered around collaboration and flexibility.

Following the contact tracing on this case, an outbreak was declared, and the role of public health inspectors expanded greatly. It shifted from purely environmental inspections of farms and living facilities to full-on outbreak management. A team of public health inspectors immediately went into planning mode and brought in the help of public health nurses. Together, and in partnership with the municipality, they employed a comprehensive response to support this population.

This Equity in Action story is distilled from an interview with Manuela Hermida (Public Health Inspector) and Natacha Peters (Public Health Nurse) from Niagara Region Public Health & Emergency Services (NRPH&ES), and Michelle Johnston (Program Manager) from Niagara Region. The interview took place in March 2022, and its details should be considered within the context of that time period.

Developing tailored and comprehensive outbreak management

Our team of public health inspectors and nurses joined forces to start conducting inspections, and complete case and contact tracing. The inspections ensured that the facilities were adhering to the COVID-19 infection prevention and control measures in place at the time. Historically, inspections were focused on ensuring the provision of safe drinking water, adequate housing facilities, etc., but now, with COVID-19, they were expanded to make sure that farmers supplied disinfectant and personal protective equipment, and conducted, recorded, and stored COVID-19 workplace screening information.

We very quickly realized that the typical COVID-19 case and contact tracing measures would not suffice for the unique needs of this population. There are cultural differences that had to be navigated. Many workers come from cultures where people believe that you are only sick when you need to go to the hospital, not when you have a runny nose or a cough. For this population, symptoms and the accompanying isolation requirements represented financial loss as well as current and potential future work loss. Seasonal workers feared that the farmer who employed them would not take them back next year if they could not work when scheduled, and thus workers were not reporting their symptoms.

There was also the barrier of literacy and technology. Out there on the farm, there was rarely Wi-Fi or access to computers. These workers wouldn't be able to fill out screening information for themselves, and we didn't have complete contact information for many of them.

NRPH&ES realized that we needed to be more flexible and adaptive than ever before to find processes that worked. We started bringing nurses out to the farms in full personal protective equipment (PPE) to work as a team and collect information from the workers to answer all the questions that the provincial Ministry of Health required. We were out there every day gaining trust, hearing more about what the workers needed, what they were missing, and what barriers, fear, or confusion they were experiencing. Our COVID-19 case management interviewing morphed into: "What is happening every day for you?" Many times, our job expanded to assist in daily life, for example, by facilitating grocery deliveries or laundry, or making sure that money was still sent home to the workers' families. Because we were there every day, we were also able to respond quickly to emergencies — we even ended up calling 911 a few times. The workers did not know they could do that.

Our approach was different every single time. We shifted and adapted to the immediate needs of the farmers and workers, and that is how we built a trusting relationship. As we went along, the process became more streamlined, and we recruited paramedics and additional interpreters to put it all together — the documenting, coordination of services, and testing. It all worked really well at the time.

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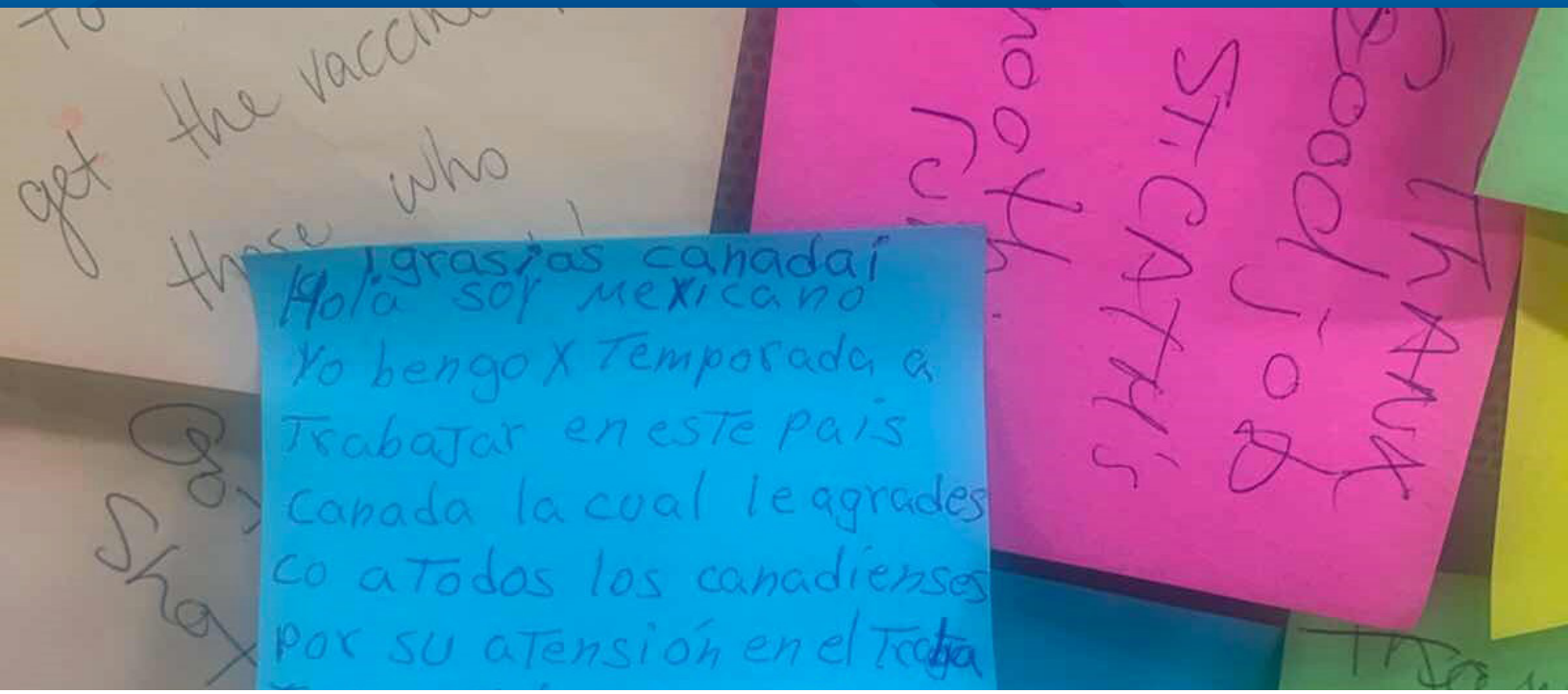
The common narrative would lead you to assume that the profit-motivated employer wants to get as much out of their workers as possible, but time and time again this was proven untrue.

Many of the farmers had strong relationships with their workers, spanning multiple generations. The farmers were such a help in this situation, many of them were exposing themselves to COVID-19 infection in order to bring workers food or take COVID-19 positive workers to the hospital. We have to give the farmers some credit. Throughout outbreak management, we built and strengthened relationships with farmers, and they have maintained those relationships with us and have called to thank us for the work we have done.



Navigating barriers and promoting vaccination among a priority population

As time went by, our work transitioned into organizing vaccinations for the population of seasonal workers. Despite the large numbers of workers in Niagara Region, health care for these individuals can be quite fragmented due to complex and lengthy processes, for example, in terms of determining access and eligibility, issuing health cards, etc. Seasonal workers arrived in Niagara Region with their own knowledge and personal beliefs about the pandemic as well as hesitancy about vaccination. These workers live and work together in isolated conditions, often only interacting with each other. We found that these conditions can lead to "group think", and a minority group of dominant voices may hold a great deal of power over the larger group's perceptions associated with vaccination. We had to navigate all of this to overcome the barriers to vaccination.

In an ideal world, to increase vaccine uptake, we would have mobile teams to bring vaccines out to farms. However, there are 489 agricultural worker congregate living facilities and well over 200 farms — it was just not possible logistically. We had to devise another solution.

We got buy-in from senior level leadership within the health unit, municipality, and hospitals to take a risk and try something different with the goal of improved access because they believed it was the right thing to do. This empowered us to host dedicated mass vaccination clinics to prioritize access for just seasonal workers and others working on farms. This required much coordination. In response to continually evolving guidance from the province, we had to quickly answer questions like how do we identify the priority population, how can we create dedicated days for this sector to get vaccinated in a physically and culturally safe environment, and how do we communicate this and get the word out to farms? We were able to leverage the corporate capacity of Niagara Region and Niagara Health to pull in Spanish-speaking folks, including doctors, specialists, paramedics, interpreters and even people outside of the health sector. We redeployed all these people to help and had a full range of support for folks on site.

Social and community organizations that serve these populations helped by distributing vaccine information posters in both English and Spanish. We highlighted that the workers could just ask questions and ultimately

walk away; there was no problem in deciding not to get the vaccine. We were just trying to get as much accurate information to this community as possible to address some of the misinformation that had been out there. For example, some workers did not believe the vaccine was free for them, and others were hesitant about specific vaccine types. Internally, we had to make sense of rapidly changing guidelines and information and then communicate that in a culturally appropriate way.

Building essential relationships for an effective community response

Being out at the farms every day allowed us to have open communication and develop trusting relationships with both the farmers and workers. These relationships made it possible to identify, navigate and overcome the barriers that this population faced at the start of the pandemic. For example, initially we didn't have an efficient way to communicate with workers, but we became trusted enough to enter the workers' WhatsApp groups and could then easily communicate valuable information. Reflecting on all of our pandemic response efforts, going to the farms made us feel like we really made a difference.

Being in the community also informed our response. We really had to be in the field to understand the ins and outs of this unique group and learn about their needs.

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We had support from the municipality, nurses, paramedics, and community organizations in meeting these needs. Quest Community Health Centre was a key support in this initiative, and churches in the area also helped by delivering food and religious support, something we learned was important for many workers. The Migrant Agricultural Worker Stakeholder group, coordinated by NRPH&ES and Quest, brought together many of these community supports to help coordinate efforts throughout the pandemic. Many of us had never been part of such a diverse team, there were so many different people creating a holistic approach.

Ensuring adequate resources and flexibility to maintain equity-driven responses moving forward

If anything, this work showed us that more adequate funding to support access to primary care for this population is key. At this moment, the funding isn't anywhere close to being able to provide quality care for 3,000 documented migrant workers. We know, and can acknowledge, that we cannot "enforce our way" out of the pandemic. There must be proportional investments in funding to support primary care for workers.

Communication between different levels of government is key. On paper, some policies make sense, however in practice on-site at a farm, we could not fill out the Ministry's online forms, it was just not feasible. There needs to be collaboration so that the policies coming from other levels of government can be implemented to meet the needs at the local level.

Niagara was the first public health unit in the province to offer vaccination clinics to seasonal workers at such a large scale. This work highlights that we can work with a lot of different organizations and, when we need to do something, it can get done quickly — we can make anything happen.

LESSONS LEARNED:

1. Successful equity-driven interventions are flexible and adapt to meet the needs of a population. Processes or requirements that are too rigid, or developed without an understanding of local context, may not be feasible on the ground.

2. Relationship-building happens in the community. By being present on the farms, public health practitioners were able to learn about and help meet the needs of farmers and workers, which helped build trusting relationships and inform response efforts.

3. Effective health equity interventions require a whole-of-community approach, which requires meaningfully engaging partners across levels of government (e.g., municipal, provincial and federal), across health and social sectors (e.g., health agencies, social services) and across community (e.g., community organizations, farm operators and farm workers) and coordinating efforts to reach shared goals.

4. Interdisciplinary collaboration within organizations (e.g., collaboration among municipal public service staff and public health unit staff from various departments or teams) allows for combining diverse skillsets to improve services and promotes shared learning among staff.

BACKGROUND

Niagara Region Public Health & Emergency Services: Niagara Region Public Health and Emergency Services is committed to providing public health programs and services, and an efficient response to the changing public health needs of communities in the region. This commitment is demonstrated through health protection, disease prevention, health promotion and injury prevention programs.

The Regional Municipality of Niagara: Niagara Region is an upper-tier level of municipal government, serving the communities of Fort Erie, Grimsby, Lincoln, Niagara-on-the-Lake, Niagara Falls, Pelham, Port Colborne, St. Catharines, Thorold, Wainfleet, Welland and West Lincoln.

Quest Community Health Centre is a non-profit registered charitable organization providing primary health care, health promotion and community capacity building to residents of the St. Catharines area and Niagara Region. It is the only centre in this region that is funded to provide services to seasonal agricultural workers.

KEYWORDS

Working conditions, structural determinants, COVID-19, social determinants, intersectoral collaboration, community engagement, interdisciplinary approach

To learn more about the initiative described in this story, contact the National Collaborating Centre for Determinants of Health at nccdh@stfx.ca.

Do you have an idea for an Equity in Action story? If you have heard of other health equity-promoting COVID-19 pandemic response initiatives in Canada that we should share, please let us know.