National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

National Collaborating Centre for Infectious Diseases

Centre de collaboration nationale des maladies infectieuses

LEARNING FROM PRACTICE:

JOINT ACTION FOR EQUITY - COMMUNITY-CENTRED COLLABORATION RESPONDS TO CARGILL OUTBREAK

WHAT'S INSIDE...

What follows is a story that illustrates how public health has worked with primary care and community organizations to improve population health and health equity. This and other Joint Action for Equity stories in the Learning from Practice Series highlight principles and practices that support improved relationships between public health and primary care, and the important role of communities in strengthening health systems.

When one of the first Alberta outbreaks of the COVID-19 pandemic occurred at the Cargill meat processing plant in rural southern Alberta, existing relationships between public health, primary care and community organizations became invaluable to the response. Relationships were key to containing the COVID-19 outbreak as well as making the response more equitable by understanding and addressing the ways determinants of health including employment and working conditions impacted COVID-19 transmission.

This practice example was distilled from a group interview conducted in August 2022 and reflections from the Canadian Public Health Association conference in Fall 2021. The story highlights perspectives and lessons learned from events that took place in 2020 and should be considered within this context.

PROJECT BACKGROUND

The goal of public health is to improve the health of populations through protection, promotion, prevention, disease and injury surveillance and responses, and emergency preparedness. Primary care supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.[10] Primary care and public health tend to operate independently, but the World Health Organization (WHO) recommends greater integration through ***primary health care***.

The WHO and United Nations Children's Fund (UNICEF) describe primary health care as a holistic approach to strengthen relationships and integrate public health and primary care services locally, with multisectoral actions to empower communities, promote population health and improve health equity.[8]

The ***Joint Action for Equity*** project — a collaboration of the National Collaborating Centre for Determinants of Health (NCCDH) and National Collaborating Centre for Infectious Diseases (NCCID) — highlights examples of sector integration and primary health care. The project profiles stories of how public health programs, primary care service providers and community members created innovative partnerships to respond to local health issues and achieve greater equity in health outcomes.

SETTING THE STAGE

In April 2020, the province of Alberta was early in the COVID-19 pandemic response. There were fewer than a thousand cases, and no large outbreaks of COVID-19 had been declared in the province.[1] However, the conditions — both on and off the job site — of those working at the Cargill meat processing plant in High River facilitated the spread of the novel coronavirus (SARS-CoV-2). For one, workers were required to be shoulder to shoulder in a crowded environment, which Cesar Cala of the community organization Filipinos Rising described as "like a tinder box for pandemic to happen." Thus, once COVID-19 transmission started in the Cargill plant, it led to an outbreak of nearly 1,600 confirmed or probable linked cases that, at that time, was the largest outbreak of COVID-19 in North America. The Cargill outbreak shed important light on how social and structural determinants of health greatly impacted infectious disease response and control.

Employment and working conditions and immigration status are important determinants of health. More than half of Cargill employees are of Filipino background. Others come from Vietnamese, Mexican, Ethiopian, and other communities who are racialized. Many Cargill workers are temporary migrant workers, refugees or newcomers who face social, cultural and economic challenges, including limited English proficiency. Policies, social norms and experiences of oppression create inequities connected to racism, poverty and precarious immigration status for temporary and migrant workers in Canada.[2] For temporary migrant workers, their ability to work and hold a visa in

Employment and working conditions are powerful determinants of health. **Employment conditions** are the terms of a worker's contract such as wages, hours and benefits. **Working conditions** refer to the on-the-job circumstances and risks that workers are exposed to.[2]

Canada is tied to the specific employer, which constricts workers' power to refuse unsafe working conditions and precarious employment conditions because they are fearful of being let go and deported.

"We are all in the same storm, but not all in the same boat."

CESAR CALA, FILIPINOS RISING (adapted from Damien Barr[3])

Cargill, Inc.

Cargill, Incorporated is a multinational conglomerate that operates in over 70 countries and regions and has over 155,000 employees. The Cargill meat processing plant in High River, a town in southwestern Alberta with a population of roughly 14,000 people, is "a fully integrated beef processing facility including slaughter, fabrication, rendering and hide operations."[11] For the past 15 years, the Cargill plant in High River has been working closely with the Alberta provincial government to recruit over a thousand temporary migrant workers from both the Philippines and Mexico.

INITIAL RESPONSE

When the first cases of COVID-19 were reported at the Cargill plant, many workers were scared to go to work. Workers and community members sent a petition to Cargill management and local government, actively voicing their concerns that the infection was spreading in the Cargill plant and calling for the plant to be shut down. However, the initial public health response focused on controlling transmission within the work site through implementing stricter workplace health and safety measures, such as increased cleaning, temperature checks, personal protective equipment and plastic barriers to separate workers. This initial public health response had limited engagement with workers and the communities who understand the lived experiences of those at the centre of the outbreak. It also did not adequately consider or address the social determinants of health that impact COVID-19 transmission, and so the outbreak grew.

Precarious working and employment conditions at the Cargill plant made workers disproportionately vulnerable to COVID-19. Virus transmission increased due to precarious employment conditions such as low wages, lack of paid sick days, and the bonuses allotted to workers who put in 8 consecutive days of work. Complying with orders to "stay home" and following public health recommendations without the necessary supports are not possible for many low-wage workers. In fact, workers may be incentivized by their employer to do just the opposite. For example, when the pandemic first started, meat and other food processing facilities were designated as essential services and Cargill offered workers a bonus if they worked eight consecutive shifts to make up for staffing shortages. For low-wage earners who often support extended family both locally and internationally, this incentive was a welcome opportunity that enticed workers to continue working even if they felt unsafe, were sick or were close contacts of someone who was sick. These financial incentives reflect larger policy issues such as ways that employers can choose short-term solutions to address staffing shortages over ensuring adequate sick pay and overtime.[2]

Transmission was also influenced by housing and transportation. Many Cargill workers live with other low-wage workers with high occupational risks of exposure to COVID-19, such as those who work in long-term care and other essential service jobs. Some workers live in crowded dwellings shared with as many as 15 residents due to a lack of affordable housing. Most workers live in Calgary and other surrounding towns as there is not enough housing capacity in High River. Workers must rely on carpooling and long commutes in crowded vehicles to get to work at the rural High River plant, which increased disease transmission.

The **structural determinants of health** are processes that create inequities in money, power and resources. They include political, cultural, economic and social structures; natural environment, land and climate change; and history and legacy, ongoing colonialism and systemic racism.[12,13]

See the NCCDH's *Glossary of essential health equity terms*[13] for this and other definitions.

The ability of workers with symptoms to isolate or their close contacts to quarantine was hindered by a myriad of issues connected to social and **structural determinants of health**. Workers encountered social determinants such as problems with safety in the workplace, lack of language supports and culturally accessible information and services, economic pressure from their employer to keep meat plants operating, financial inability to be off work without pay, and economic necessity for shared or crowded housing and transportation.

Immigration status is a powerful structural determinant of health. Oppressive immigration policies — such as single-employer visas that bind a worker to one job and denying temporary migrant workers permanent residency — decrease a worker's power to self-advocate.[2] Cala, community convenor from Filipinos Rising, further explained how immigration policies isolate workers from their loved ones and create a power imbalance between workers and employers. "Temporary foreign workers also cannot bring their spouses and children with them to Canada. The hope of becoming permanent residents and bringing their families over hinges on the sponsorship of the employer," Cala shared.

"We are all in the same storm, but not all in the same boat,"[3] said Cala when reflecting on the unjust and unequal social and structural systems that made it more challenging for Cargill workers to avoid COVID-19. These structural inequities were important contributors to the perfect storm of the COVID-19 outbreak at the Cargill plant.

ADAPTING THE RESPONSE TO MEET COMMUNITY NEEDS

When the number of cases at the Cargill plant continued to climb despite workplace measures to reduce transmission, the Government of Alberta mandated Alberta Health Services to contact every Cargill worker household within 3 to 5 days with information about COVID-19. Dr. Jia Hu was a Calgary Zone medical officer of health and knew that further action was urgently needed to prevent spread. Public health needed a broader, whole-system response to consider and mitigate the structural inequities that were contributing to disease transmission among workers. Public health engagement had to extend beyond the Cargill corporation.

Dr. Hu reached out to Dr. Annalee Coakley, primary care physician at Mosaic Clinic, as many of her clients were Cargill employees. Together, and heavily leaning on connections between primary care and community organizations, they reached out to community groups such as ActionDignity and Filipinos Rising. As well, they engaged the Cargill union to better understand the experiences of workers.

What happened next was an unprecedented coordination of community organizations, primary care across the Calgary Zone, and public health. Unlike the initial response that involved only the employer and public health, this much broader response involved pre-existing primary care networks, newcomer organizations, and public health response teams. These partners rapidly mobilized and collaborated through establishing data-sharing processes, referral pathways, and methods of communication. This allowed them to better address the social determinants of health and facilitate clinical care for impacted workers and families, which helped curb ongoing transmission. Acting

on the social determinants of health included prioritizing language resources, housing needs, and food security.

As part of the public health response, testing for asymptomatic infection was used for the first time in Alberta. When workers tested positive, they were notified by public health of the positive swabs and told to isolate for 10 days, whether or not they had symptoms. Though asymptomatic testing improved diagnostic sensitivity and the public health response to outbreaks, workers diagnosed with COVID-19 still faced many challenges, such as lacking the space required for isolation. As part of the collaborative response, the first series of isolation hotels in Alberta supported by provincial funding was set up to respond to COVID-19. This strategy of isolation hotels was applied in later outbreaks among people living in unstable or crowded housing. Public health, primary care, and community organizations partnered to support workers to isolate and quarantine by meeting the needs of individual workers and their communities.

Workers and their families trusted the community organizations and readily shared their experiences. Cala recounted how the "involvement of Filipinos Rising, ActionDignity and its member organizations helped in communicating with the workers through their languages and in culturally respectful ways. The workers and their families also readily shared their situations and other issues that they were facing." Community organizations were trusted and privy to the deeper issues the workers were facing such as "safety in the workplace, being blamed for the spread of COVID, discrimination in their neighbourhoods because they were Cargill workers," said Cala. Some workers faced hostility, racism, stigma, and even eviction from their residence. The community organizations were able to share this knowledge and advise public health and primary care providers on how to better support infected workers and families.

To support those who tested positive and reduce infection transmission among close contacts, public health connected with primary care through existing relationships with the Mosaic Primary Care Network. With guidance from community organizations, primary care provided isolation coaching, COVID-19 follow-up, and the offer of hotel isolation. Primary care teams made up of physicians, nurses, and other allied health providers connected daily with people who tested positive for COVID-19, offering services such as medication delivery and supportive counselling. They also supported referrals to local immigrant-serving agencies that helped with tailored needs, such as social housing, culturally appropriate emergency food packages, and counselling to landlords to mitigate stigma and threatening behaviour towards tenants.

Marichu Antonio was the executive director of ActionDignity at this time and shared how community organizations were integral to supporting a culturally respectful COVID response and to building health literacy for workers and families:

> ActionDignity and various ethnocultural community organizations trained first-language callers to directly phone workers and family members in their first languages, such as Filipino, Amharic, Vietnamese, Spanish, Arabic, etc. Using the approach of "healing with dignity," these calls provide a safe and trusting space where workers and their family members shared their situations and their needs ranging from health, rent, food, transportation, safety in the workplace and fears about their immigration status. These first-language callers were able to explain complicated isolation procedures and other health and work-related issues to the workers. ActionDignity and community groups also came up with various culturally appropriate food packages that can be delivered for 2 weeks for Asians, Ethiopians, Sudanese, Hispanic, etc. These first-language callers also mobilized workers and their family members to attend online consultations, education sessions and open forum [to] answer their many questions.
>
> MARICHU ANTONIO

The remarkable cross-sectoral approach to engage and support workers and their close contacts helped limit transmission within households and to the wider community, but it was too late to prevent infections among 943 Cargill employees and 642 household contacts. Tragically, three deaths of workers or their family were linked to the Cargill outbreak: Benito Quesada and Hiep Bui were both workers at the Cargill plant, and Armando Sallegue was the father of a worker.[4] Several workers also suffered long-term post-COVID effects and were hospitalized, requiring intensive care and long-term rehabilitation These preventable deaths and injuries highlight the critical need for public health to work directly with those exposed to precarious work to better address the multiple social and structural determinants impacting their health, and to advocate for **decent work** through strengthened employment standards, laws and strong worker-led organizations and unions.[2]

Although the outbreak at the Cargill plant spread widely among employees, the collaborative response of public health, primary care and community organizations limited wider community spread during the first wave of the

Decent work promotes safe and dignified working and employment conditions for all workers:

> If precarious employment is the problem, decent work is the solution. Decent work is a shared vision — it is a common goal, an agenda for policy and legislative change, and a movement to confront precarious employment that is aligned with a social determinants of health and Health in All Policies approach. Collaboration through intersectoral action is essential to advance the decent work vision and build healthier communities after COVID-19.[2(p27)]

Learn more in the NCCDH's *Determining Health: Decent work issue brief*.[2]

REMEMBERING BENITO, HIEP AND ARMANDO

Hiep Bui, 67, who loved to give sweets and candies to her coworkers, was fondly called "Candy Mama" by her coworkers. She was a refugee from Vietnam who dedicated 23 years of work in Cargill and hardly used her sick hours. Hiep was the first in Cargill to die, 3 days after she contracted COVID in mid-April 2020.

Benito Quesada, 51, was a hard-working man from Mexico who worked for over 10 years in Cargill. He was a dedicated spouse, a loving father of four young children and a caring union shop steward who wanted to help his coworkers. He contracted COVID in April 2020 and died in the hospital several weeks after.

Armando Sallegue, 71, was a widower from the Philippines who came to visit his son Arwyn and his family, including his four grandchildren. Armando developed symptoms the day Arwyn, who works in Cargill, tested positive for COVID. Armando died in the hospital in May 2020.

The NCCDH and NCCID thank Marichu Antonio for writing these words of remembrance.

pandemic in Alberta. COVID-19 catalyzed new models of partnership between public health, primary care and community organizations. Lessons from this collaborative response to the first Cargill outbreak were carried forward to further pandemic responses. Public health further engaged with primary care and community organizations in the initial response to other outbreaks. Further, governments increased their support for individuals and families who require isolation and quarantine.

LEVERS FOR SUCCESSFUL PARTNERSHIP

The NCCDH and NCCID have published a précis of a situational analysis exploring the relationship between public health and primary care that discusses eight strategic levers to support improved relationships and partnerships between public health and primary care.[5] These strategies could be further leveraged to better work towards systems-level change rooted in health equity. Several strategic levers are showcased in the partnership between public health, primary care, and community organizations that supported the Cargill outbreak response:

Establishing formal networks

In the context of the Cargill response, primary care formed the bridge between public health and the community. Dr. Hu, who worked as a medical officer of health, reflected that it was through Dr. Coakley's position and connections within primary care that partners from community organizations were engaged and determinants that drove COVID-19 transmission were addressed. Partnership was integral to curb the Cargill outbreak. These partnerships relied heavily on existing relationships that developed from previous collaborations. For partnerships to be sustainable, relationships should be established, strengthened and institutionally supported prior to crises.

> "Partnerships need to be formalized. They need to be entrenched in the system, and there has to be a way of moving information and communicating between Alberta Health Services public health and our social agencies."
>
> DR. ANNALEE COAKLEY, PRIMARY CARE PHYSICIAN
> MOSAIC CLINIC

Although networks and collaborative processes were temporarily formalized during the COVID response, they no longer exist due to the end of funding. However, relationships endure beyond the end of the formal collaboration and can enable future partnerships.

"In the absence of such mechanisms, the continuity of the collaborative experience becomes embedded in less formal 'personal' relationships. And as such these relationships are less valued — rather than recognized and acknowledged as place holders of good collaborative memory."

CESAR CALA, FILIPINOS RISING

Increasing community governance and engagement

Community leadership and engagement were instrumental in curbing the spread of COVID-19 among Cargill workers. Communities know their needs best as well as the solutions to meet those needs. Antonio highlighted the importance of centring the community at the decision-making table, from the planning to implementation stages of all interventions.

"These are the people who are experiencing these issues and usually have new innovative approaches that need to be incorporated."

MARICHU ANTONIO, RETIRED EXECUTIVE DIRECTOR OF ACTIONDIGNITY

Strengthening data, surveillance and digital systems

Data sharing was integral in allowing community organizations to contact and support workers who needed to isolate. To urgently actualize government-mandated isolation and quarantine and to ensure adequate medical care, data sharing between public health, primary care and community had to occur. The intimate experiential knowledge and connections of community organizations complemented primary care knowledge of clients and was supported by public health expertise of population health planning and infection control protocols. Formalized data-sharing agreements between communities, public health, primary care and community organizations would enhance responses to future crises.

LESSONS LEARNED

Centre the work of relationship-building

The relationships between public health, primary care and community partners were integral to seeing and responding to the needs of the workers and communities impacted by the Cargill outbreak. The ability to act quickly was because of the relationships that were in place prior to the crisis, yet relationship-building is often institutionally undervalued. Public health should see building partnerships with primary care and communities as part of its mandate. These relationships must be more than just transactional — they need to be based on trust, reciprocity and equity. Improved relationships between public health, primary care and community organizations can be synergistically leveraged to advance health equity.

"Relationship building is indeed crucial. Relationship that is based on mutual trust, mutual respect, and equitable relationship, especially in bringing communities around the table with other players."

MARICHU ANTONIO, RETIRED EXECUTIVE DIRECTOR OF ACTIONDIGNITY

Recognize that different roles bring different strengths

In the Cargill response, primary care physicians — like Dr. Coakley — knew the workers, the impacted communities and the community organizers who could best support the response and the people. Primary care physicians also knew the COVID-19 medical care pathway. In addition to providing medical care, primary care providers could act as connectors and bridge builders. Public health professionals have the means and training to best assess transmission risks and the status of the outbreak and provide formal linkages to other government agencies such as occupational health and safety. Independent community organizations provided critical feedback, unconstrained by institutional mandates and risk aversion. Community organizations are thus able to lead creative innovations to promote health equity that could be more challenging for health systems to implement. When each partner's strengths and limitations are recognized, collaboration improves. Synergistically primary care, public health and community organizations can accomplish more than what is possible on their own.

Embed networks into formal structures rather than relying solely on champions

Although successful partnership in the collaborative COVID response was largely due to engaged leaders who trusted each other and were willing to work together, a lesson learned is that formalized relationships — such as committees or task forces — supported by funding and data-sharing agreements are integral for coordinated and sustained action. Formal structures between public health, primary care and community organizations would ensure continuity of these relationships, better supporting a system that can address health inequities and better respond to future crises. However, when considering formal networks, Cala pointed out a need to better centre community organizations:

"Many attempts at institutionalizing these kinds of experiences end up marginalizing community groups and privileging already established organizations, social agencies and public institutions."

Communities know how to support their health. In addition to addressing workplace transmission, modifying the COVID response to account for modes of transmission outside of the workplace needed the knowledge of workers' experiences. Communities know their needs best, and integrating community knowledge was essential to curb COVID-19 transmission. Communities which are invested in have the potential to bring innovative approaches that are better tailored to specific needs. However, Antonio cautioned that service provider organizations should not be conflated with community organizations—such as ActionDignity and Filipinos Rising—which do community organizing and are comprised of members from the community:

"Communities, in our case at ActionDignity, pertain to racialized and ethnocultural organizations and communities, including essential workers and their families, that played a big role in the COVID response. These sections of the population are different from service provider organizations that are funded to provide direct services.... Service provider organizations alone should not be seen as the sole representation and voice of the community."

MARICHU ANTONIO, RETIRED EXECUTIVE DIRECTOR OF ACTIONDIGNITY

Employment and working conditions are powerful determinants of health

Close working conditions, low wages, lack of paid sick days, and incentives to work overtime all played a part in the spread of COVID-19 in the Cargill plant and community. To promote health equity, public health can involve workers in decisions, support worker-led organizations and advocate for decent work through stronger employment standards acts and immigration reforms.

LOOKING AHEAD

Reflecting on lessons learned from the collaborative response to the Cargill outbreak, multisectoral engagement and integration of worker and community knowledge were key to curbing COVID-19 transmission. The clear benefits demonstrated when public health and primary care partner

QUESTIONS FOR REFLECTION

- **Where can networks be formalized between public health, primary care and community organizations?**
- **How can public health, primary care and communities encourage and build health literacy?**

Cala further encouraged public health and primary care to reflect on these questions:

- **How do you encourage, support and build capacity for cooperation and collaborate before crises start?**
- **How can communities better prepare to engage larger systems that often exclude them from planning and decision-making tables?**
- **How can we build more durable mechanisms that are relational rather than just transactional?**

with communities can be extended to envision health system transformation towards health for all, as articulated in the WHO's vision for primary health care (including the 1978 WHO Declaration of Alma-Ata[6] and 2018 WHO/UNICEF] Declaration of Astana[7]).

According to the WHO and UNICEF, "better health outcomes, improved equity, increased health security and better cost-efficiency make primary health care the cornerstone of health systems strengthening."[8(pXIX)] Primary health care provides a framework for health system renewal in Canada, resting on the building blocks of communities who are invested in and who act as codevelopers and advocates for policies and programs that protect and enhance their health and well-being.

The lessons learned in the Cargill outbreak reflect the power of engaged communities and multisectoral collaboration to support and enhance the efforts of public health and primary care in striving for health equity. The lessons learned from the collaborative response to the COVID outbreak at the Cargill plant were carried forward and applied during the Calgary Northeast COVID-19 response and immunization roll-out. Read more about this community-led response and the establishment of a multilingual telephone line in the NCCDH's Equity in Action story: *Culturally appropriate COVID-19 supports are only a phone call away through the Calgary East Zone Newcomers Collaborative*.[9]

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