



# National Advisory Council on Migrant Health

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July 23, 2021

The Honorable Secretary Becerra, J.D.  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Secretary Becerra,

The National Advisory Council on Migrant Health (NACMH, hereby referred to as “The Council”) advises, consults with, and makes recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) and the Administrator, Health Resources and Services Administration (HRSA). Specifically, the Council is charged with reviewing the health care concerns of migrant and seasonal agricultural workers (MSAW), and the organization, operation, selection, and funding of migrant health centers (MHC) and other entities assisted under section 330(g) of the Public Health Service (PHS) Act, as amended, 42 USC 254(b), with the goal of improving health services and conditions for MSAWs and their families. Please find an overview of the Council’s May 2021 meeting and three key recommendations that fulfill our charge.

## *Overview*

In adherence to safety measures and travel restrictions related to the COVID 19 public health emergency (PHE), the Council’s May 2021 meeting was convened virtually. The Council met over 4 half-days, May 25-28, 2021. During the meeting, we received updates from HRSA senior leaders:

- Jennifer Joseph, PhD, MEd, Director, Office of Policy and Program Development (OPPD), Bureau of Primary Health Care (BPHC), HRSA
- Tracey Orloff, MPH, Director, Strategic Partnerships Division, Office of Quality Improvement (OQI), BPHC, HRSA

We also heard presentations from the following migrant health stakeholders:

- Seth M. Holmes, MD, PhD, University of California, Berkeley and San Francisco; Associate Professor, Society and Environment; Equity Advisor, Medical Anthropology; Co-Chair, Berkeley Center for Social Medicine; Author: Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States - Structural Inequities Fueling Health disparities, Including the Disproportionate Impact of COVID 19 on MSAWs.
- Sarait Martinez, Ed.D, Executive Director, Centro Binacional para el Desarrollo Indígena Oaxaqueño - Indigenous MSAWs in the US: Their Vital Contributions and Unique Challenges

- Alfonso Rodriguez Lainz, PhD, Epidemiologist, Centers for Disease Control (CDC), Deployment Globally Mobile Populations Team (Global Migration Task Force) - Strategies to Prevent and Mitigate COVID 19 Among Agricultural Workers: A CDC National Center for Farmworker Health (NCFH) Partnership
- Sylvia Partida, MA, Chief Executive Officer, NCFH - Strategies to Prevent and Mitigate COVID 19 Among Agricultural Workers: A CDC NCFH Partnership
- Rachel A. Gonzales-Hanson, Senior Vice President for Western Operations, National Association of Community Health Centers (NACHC) – NACHC Update
- Iris Figueroa, JD, Director of Economic and Environmental Justice, Farmworker Justice – Addressing the Social Determinants of Agricultural Worker Health Using Medical-Legal Partnerships
- Alexis Guild, MPP, Director of Health Policy and Programs, Farmworker Justice - Addressing the Social Determinants of Agricultural Worker Health Using Medical-Legal Partnerships

The Council also received first hand testimonies from 7 MSAWs and 3 patient advocates/promoters from Wilsonville and neighboring areas in Oregon, which is home to approximately 35,000 farms and ranches which grow and raise over 225 different crops on 16.3 million acres.<sup>i</sup> There are an estimated 174,000 seasonal and migrant farmworkers in the state.<sup>ii</sup> The total number of workers on the farms and ranches is approximately 4 percent of Oregon’s population, including paid and unpaid on-farm workers.<sup>iii</sup>

Hearing testimonies from Oregon farmworkers was both timely and essential. The exacerbation of barriers to health brought on from both the COVID 19 global pandemic as well as by unprecedented wildfires in Oregon demonstrated that farmworkers are on the climate crisis’s front lines. As a group, they experienced disproportionately higher rates of COVID 19. For example, in the 13-month period from March 1, 2020 to March 31, 2021, the estimated incidence rate of COVID 19 deaths was 9.55 percent, 9.31 percent, 9.39 percent, and 9.01 percent of U.S. agricultural producers, hired workers, unpaid workers, and migrant workers, respectively.<sup>iv</sup> This COVID 19 incidence rate is higher than the general population. <sup>v</sup> Moreover, the rate is also significantly higher in counties with more agricultural workers. And although we know this, “most farmworkers never stayed home or went into isolation, as the fear of losing a job was a significant barrier to accessing COVID 19 testing and care.”<sup>vi</sup> During the testimony period, a mother said it this way:

*“My daughter got sick in the middle of the night. I took child to the emergency room and took of work the next day. By the following day, I got a call “There is no more work for you.”*

For farmworkers, this is not something that happens “once in a while”. In too many cases among testifiers, workers were having to choose between work and health.

Additionally, the unprecedented wildfires highlighted a potential gap in Oregon's workplace regulations. First, current workplace policies do not detail how employers should respond to extremely poor air quality related to wildfires. This is a gap that must be addressed, as it puts farm laborers and their families in positions that could jeopardize their health. Though Oregon's Occupational Safety and Health division (Oregon OSHA) issued a notice "urging employers to stop or delay outdoor work activity" while the air was unhealthy or hazardous, the OSHA notice was a mere recommendation. It was not an enforceable requirement. Thus, some farm laborers stayed on the job in hazardous atmospheric conditions.<sup>vii</sup> Environmental threats are a threat to health. The Oregon wildfires exacerbated the impact of COVID 19 on both MSAW's health and housing. Many MSAWs continued to work 8-hour shifts or more during days when the levels of oxygen were at their worse. But it was "*because they had no other choice*". As one farmworker stated,

*"When authorities were telling people to stay at home, the migrant workers were in the fields, prepping the land for harvesting or planning. Making sure that the rest of the people had something on their tables."*

With these circumstances at the backdrop, we heard testimonies around conditions that impact MSAW health. Three (3) key themes emerged:

1. **COVID 19 exacerbates the already overwhelming impact of social determinants that negatively impact MSAW's health.** The lack of linguistically and culturally appropriate communication around COVID 19 to MSAW populations was particularly pronounced, and false, misleading information added to gaps in care. During the testimony period nearly all farmworkers mentioned the fear of losing their job and not being able to provide for their family financially. Thus, they chose to work under whatever conditions were available to them – even if unsafe during the height of the COVID 19 infections. This also led to increased infections among farmworkers who lacked necessary personal protection equipment (PPE), social distancing, or the ability to self-isolate. One particular farmworker was quoted, saying,

*"I am positive that I put people that work around me at risk."*

Moreover, misinformation was rampant during the testimony period. Another farmworker said that when he took the test to determine if he had COVID 19, he was told that although his results were positive for infection, he did not need to keep quarantine. That farmworker suggested that he has no idea how many people may have been infected because of this misinformation.

2. **Farmworkers who speak indigenous languages are not able to access linguistically appropriate care.** Among our testifiers, those who spoke an indigenous language, or had family members whose sole language was an indigenous Mexican language (Mixtec, Zapotec, Mazatec, etc.), were often confused about how medication should be taken. They also experienced miscommunication about surgical procedures and access to care. For example, one farmworker testified that her sister went to the wrong clinic, and nearly received the wrong surgery because of a language barrier. She stated,

*“We are from Oaxaca and we speak Mixteco. My family and I both speak Spanish and English, but my sister only speaks Mixteco. So for her, there is always this language barrier in communication. Once, she had an appointment for an operation. We travelled from our house with her for 4 or 5 hours. But when we arrived the surgery that was scheduled was not the right one for her diagnosis. She misunderstood. She had to wait longer for her surgery because she did not understand. What she understood is that they were going to operate on her to alleviate her pain. So she complied and went to a place that would have given her the wrong surgery. So, she had to wait for one more week and we had to travel with her again because she did not get an interpreter, no interpretation service.” In this example and others, indigenous workers said, ‘We will go but we will not understand anything.’*

To give support, our testifier shortened her working hours to act as an interpreter between her sister and the doctors, which made her situation of extreme poverty worse. Unfortunately, despite her sacrifices, her sister died of cancer. As HRSA continues to strive toward language equity in the provision of care for the MSAW population, we hope that this testimony will be heard in order to improve interpretation services for indigenous patients.

- 3. Finally, increased availability of care is not enough when the high cost of preventive services impedes access.** In the rural areas of Oregon, barriers to care are not only related to physical access, but also center around cost, rurality, and the lack of health insurance. One farmworker was quoted, saying,

*“People are on waiting lists and some of them do not even get called back. I know that from my personal experience, my dad needs dental work, and the treatment was quoted for \$55,000 to have his dental treatment, but who has \$50,000 in their pockets?”*

Another farmworker stated,

*“I used to go to a what was called a ‘free’ clinic. They charged me so much money that I was scared. The bill was \$700. I’m still paying that bill.”*

A third farmworker was quoted, saying,

*“I haven’t had a pap smear because I am paying the other bills.”*

This sentiment was repeated by every testifier. The consistency of lack of affordability in care resonated strongly with the Council.

At the close of the meeting, the Council received public comments from Dr. Gayle Thomas, Medical Director of the North Carolina Farmworker Health Program, Dr. Gira Ravelo and Ms. Norma Marti, Community Co-Leads, LatinX Community Response Team of the National Institute of Health (NIH) University of North Carolina Community Engagement Alliance (CEAL) program, as well as council member Mr. Angel Calderon.

Dr. Gayle Thomas, Medical Director of the North Carolina Farmworker Health Program's comments included:

- North Carolina Farmworker Health Program efforts on a broadband program to be made available at migrant labor camps in North Carolina, which will allow blood pressure monitoring.
- A vaccine program was initiated in March of 2021 by the North Carolina Department of Health and Human Services for farmworkers statewide. North Carolina teams were staffed with employees from farmworker health clinics, local health departments, North Carolina Cooperative Extension agents, community health workers, farm labor contractors and farmers. Together, this served as a model for how different constituencies can come together to help the farmworker COVID 19 education and support effort. The creation of the vaccine program was described as follows:
  - Initial and recurrent meetings were held with local teams in 56 of the 100 counties of North Carolina, including all 28 counties identified as priority counties based on farmworker density and harvest schedules.
  - The teams used the Johnson and Johnson vaccine. Little to no hesitancy was observed among MSAW populations. Additionally, H-2A farmworkers were vaccinated upon entry into North Carolina prior to being deployed to their work locations.
  - As of May 14, 2021, 148 of the 172 H-2A workers who arrived were vaccinated. Similarly, as of May 15<sup>th</sup>, 272 of the 292 MSAW's (who are not H-2A workers) were vaccinated. The week following the NACMH meeting, the NC Farmworker Program was expecting 535 workers to arrive. They expected to vaccinate as many farmworkers as are willing.

Dr. Gira Ravelo and Ms. Norma Mart, Co-leads, NIH LatinX CEAL Response Team's efforts and challenges were expressed as follows:

- The NIH CEAL Team affirmed their goals to provide trustworthy and accurate information and to use rapid research approaches to find effective ways to deliver information to communities hardest hit by the pandemic, specifically MSAW.
- The team indicated that information about COVID 19 is reaching farmworkers. However, the reliability of that information varies, and that farmworkers have been confused by contradictory information in the media. It was mentioned that MSAWs receive information from the WhatsApp Mobile Communication Platform, Facebook and media programs with Dr. Anthony Fauci.

Finally, Council member, Angel Calderon reflected on his experiences within the community of farmworkers he serves during the pandemic. He wished to be quoted as saying,

*"I must mention that the agricultural worker community in our nation has, seriously, suffered throughout the pandemic. As the son of a farmworker, I can attest to the fact that putting food on the table for our families is the priority of every farmworker parent. The best I have said about my father, to those who understand, is that 'we never went hungry!'. It has been, in my experience, a very powerful statement. This is a statement that I continued to hear throughout my life. For a farmworker, the task of putting food on the table for the family persist in the XXI century.*

*The Covid 19 pandemic took this commitment to a scary and dangerous level. I know of farmworkers who were afraid to stop working for fear of failing to provide for their families; and were afraid to work for fear of contracting Covid 19. Not many other work forces in America had the emotional/mental challenges every day to make ends meet -- Not an easy place to find oneself. The tremendous loss our farmworker communities suffered is, in my opinion, monumental. Families lost both grandparents in a matter of days. Children lost their father, the sole provider in some cases, to Covid 19. These families are still in shock. Some are wondering how to continue with the burden of their losses.*

*We found out how lethal the pandemic has been in our agricultural worker communities. Families continue to function, with what I call, frozen grief due to their inability to mourn their loved ones properly and traditionally. Our friends and neighbors had to follow Covid Management protocols and bury their loved ones immediately. No time for funerals or the spiritual ceremonies associated with death. I strongly feel that we became desensitized by the loss of those we knew and loved. Covid 19 is lethal.*

*My recommendation to Secretary Xavier Becerra is very simple. We as a nation cannot and should not forget how lethal this pandemic has become. Our migrant health clinics must receive the proper funding for a Promotora system that will seek to educate over the benefits of the vaccines available. This would include a system, much like the Migrant Education Program, of following our seasonal/migrant agricultural workers in the migrant 'stream'.*

*There is an urgent need for mental health promotores/community health workers (CHWs) with training that may be able to help patients process unresolved grief and develop empowerment skills to continue providing for their families. Our CHWs can also organize community vigils to remember those we lost to the pandemic. Our MSAWs must continue working to contribute, not only to the greatness of our nation, but to continue providing for their families. ”*

### ***Recommendations***

In context of the evidence, testimonies, and public comments heard, and in accordance with the charge given to the Council, we submit the following recommendations for your consideration:

***Recommendation I - Structural Inequities that Influence Social Determinants of MSAW Health***

The COVID 19 pandemic shed light on the nation's reliance on MSAWs. Concurrently, the pandemic also shed light on the structural inequities that define their lives. Thousands of farmworkers were deemed essential and continued to tend and harvest the crops that put food on American tables during the COVID 19 pandemic while others sheltered at home. During this time, farmworkers lacked basic rights and protections for appropriate PPE. Farmworkers also endured persistently low wages, overcrowded or unsafe housing conditions, and lacked access to care via health insurance. Even for H-2A workers, despite their authorization to work in the US, they were bound to a single employer and without access to legal resources when they experienced workplace exploitation and abuse. A Southern Poverty Law Center 2013 Report documents guest workers are routinely cheated out of wages, obtain low-wage, temporary jobs, and are held virtually captive by employers or labor brokers who seize their documents. Thus, guest workers are often subjected to human trafficking and debt servitude, forced to live in squalid conditions, and denied medical benefits for on-the-job injuries.<sup>viii</sup> The aforementioned points to only a few of the sources and effects of social inequality that are social determinants of health. Moreover, structural vulnerabilities make their way into clinical settings through stigma and fear, insufficient language access, lack of continuity of care, discrimination, and regulatory issues that impact the physical and mental health of agricultural workers in ways beyond their control.

***The Council therefore calls the Secretary's attention to MSAW structural vulnerabilities and specifically recommends the following interventions for change:***

1. HHS adopt an ethnographic approach to address structural barriers, utilizing interagency efforts to understand health and health care in the context of social, political and economic structures. The HHS family of agencies collaboratively prioritize investments in health care delivery, research, interventions, policies and programs to focus on structures that affect the health of underserved populations. Some of this information requires a first-hand view of what is actually happening on the ground. It is imperative, then, that CDC and the NIH support rigorous ethnographic research to advance the knowledge on structural vulnerabilities. This is a necessary first step to fix the underlying complex problems. This, however, must be accompanied with measuring disparities to build an evidence base of what works
2. The Office of the Secretary engage/collaborate with the Department of Labor (DOL), Occupational Safety and Health Administration (OSHA) to prioritize farmworker health in all of DOL, OSHA policies and towards obtaining a renewed commitment to ensuring safe working conditions for farmworkers, including during wildfires. This would include a wider implementation of existing regulations to protect agricultural workers in order to fill the gaps in MSAW health protection disparities. This commitment has the potential to address the social determinants of health outside of medical care, such as promoting labor rights, preventing wage theft during national or global disasters, sanitary housing, housing with access to electricity and safe water, safe working environments, safe transportation, access to broadband and PPE.
3. The Secretary's office spearhead implementation of a plan to eliminate the structural barriers that MSAWs currently experience, utilizing all available channels to increase awareness among law makers, regulating agencies, and employers including (but not limited to):
  - a. Removal of the exclusion of farmworkers from overtime pay, minimum wage and other worker protections like collective bargaining.<sup>ix</sup>



- iii. Language and communication barriers which affect ability to communicate symptoms or understand recommended treatments (e.g. indigenous languages).
- e. *Health centers diversify the health care workforce by embedding community health workers in care teams specifically directed at agricultural workers to conduct community outreach, engagement and education to address lack of familiarity about workplace rights, community isolation, language differences, cultural barriers and immigration issues.*
  - i. Recruit and train community health workers from the community to be served to assist with building trust and increasing communication effectiveness. Trust is a critical issue in reaching out to agricultural populations.
  - ii. CHWs act as ‘bridge builders’ for agricultural workers to the community and resources.
  - iii. CHWs can also help decrease MSAW isolation and can assist with transportation and finding enabling services.

## **Background**

To understand health and health care in the context of social, political and economic structures, and confront and respond to the social, political and economic structures that produce health inequities, we must broaden the frame we view health and health care through.<sup>xiv</sup> Paul Farmer a renowned medical anthropologist and physician recognizes that there are social arrangements that put individuals and populations in harm’s way. The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people.<sup>xv</sup> Structural vulnerability is not caused by, nor can it be repaired solely by, individual agency or behaviors, understanding this is critical in order to address the fundamental causes and avoid explicitly or implicitly blaming patients or communities for the risk that an individual experiences as a result of structural violence.<sup>xvi</sup>

The intra-and interpersonal dynamics during the health care encounter are equally important. Intra-personally, the doctors, nurses, and advocates are often thinking structurally, at least to some extent, even if not explicitly. It is important to ensure they are open to seeing their patients as people within the full context of their own lives and the lives of history and holding that context accountable. Inter-personally, then, patients, are understood and empowered and can be full partners in the process, improving their own health. Structural Competency (SC) is the capacity for health professionals and health systems to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures. Research indicates SC is effective in shifting health professionals’ understandings of disease and health. Current medical education, before SC training ascribes health and disease to genetics, behavior, and culture. SC training opens providers understanding of health and disease to include the role of racism, harmful policies, and unequal resources. This enables health professionals to gain increased empathy and solidarity with underserved communities and patients. Additionally, SC training emphasizes structural humility and encourages *collaboration with patients and communities* in developing understandings of and responses to the structural determination of health. Addressing inequalities in clinical settings requires that clinicians attend to, and mitigate the social structures that shape and enable the underlying assumptions. Promoting awareness of structural forces serves as a first step toward promoting recognition of the web of interpersonal networks, environmental

factors and political/socioeconomic forces that surround clinical encounters and influence care provided and health outcomes.

While we acknowledge that HRSA supported community-based health centers have focused on social determinants of health since their inception, there is room for improvement regarding the amelioration of bias. HRSA supported centers are uniquely positioned to collect data on the social determinants and enabling services, as well as expand enabling services. This supports the expansion of value-based care (mentioned above) for improved outcomes at lower costs.

### ***Recommendation II – Access to Care***

The need to leave work to seek health care and enabling services is an established barrier to care for MSAW. The North Carolina Community Health Center Association learned that traveling to their state's migrant camps to conduct the enrollment process significantly improved farmworker participation. These efforts eliminated the loss of work and transportation barriers that many farmworkers experience. Telehealth has also presented a means to providing health care to underserved populations, but much work is still needed to make this technology accessible and affordable to MSAWs. The testimonies received by the Council had a recurring theme regarding problems associated with accessing health care within clinics due to the: a) limited evening and weekend hours of operation, b) language barriers, and c) the cost of care. These are just some of the barriers that the MSAWs face when trying to access health care services.

HRSA has prioritized increasing access to high need populations, including providing a broader range of services through the use of innovative delivery models. To increase access and reinforce these priorities, we believe that mobile units, telehealth, and “*Promotores*” programs would help to promote better MSAW health outcomes.

### ***The Council makes the following recommendations to improve access to MSAW health care:***

1. *HRSA support migrant, and community health centers (M/CHCs) and fund mobile units to deliver care to the MSAW population at farms and migrant camps in their service areas. Additionally, allow flexibility for health centers to utilize their grant funded mobile units during the off season so that critical services to marginalized populations can continue.*
2. *HRSA support and equip M/CHCs with telehealth services, allocating sufficient funding and guidance for telehealth equipment, personnel, training, and protocols; and implementing telehealth systems tailored to MSAWs. Funding provided include support for appropriate technology solutions to overcome barriers associated with limited bandwidth, and to create programs that function with low-tech phones that farmworkers may own. Migrant health center enabling services plans ensure that the cost for accessing care through telehealth is consistent and affordable for MSAWs and is assessed at the patient level.*
3. *HRSA support new health center sites in areas that have overcrowded clinics and long appointment wait times by providing the economic support needed to open clinics at hours that are convenient for MSAWs.*
4. *HRSA oversight ensure MHCs provide language access services for locally spoken languages including Haitian Creole, Spanish, and Indigenous languages.*

5. *HRSA ensure the Sliding Fee Scale (SFS) Program requirement is appropriately implemented to promote access for MSAWs, and require MHCs to assist MSAWs access to affordable insurance.*
6. *HRSA fund MHCs to start, and maintain a Promotores Program, to enable MHCs to include promotores as a part of the “Care Team.” Including CHWs as a part of the workforce and not volunteers, with full access benefits and health insurance for the CHWs that serve the MSAW population. Outreach is a vital part of keeping MSAWs healthy and informed, and the best resource to make this happen are the promotores.*

### **Background**

MSAWs face numerous barriers to accessing health care.<sup>xvii</sup> For example, as a result of long work hours, and with no control over their work schedule MSAWs often cannot get to a clinic before it closes, this is further complicated by the distance they may have to travel, loss of income, lack of transportation, fear of the medical system and immigration officials, and language barriers as in the case of MSAWs who speak Haitian Creole and Indigenous languages.<sup>xviii, ix, xix, xx, xxi, xxii</sup> . Information obtained suggests that local health centers do not always have resources such as telehealth, mobile units, and promotores to reach the MSAWs in isolated and rural locations. Although HRSA has a SFS, often improper implementation leads to erroneous billing because MSAWs only work seasonally, but when they present their paychecks, the seasonality of income is not considered which creates the illusion that they earn a higher salary over the year. A third of all farmworkers have total family incomes below US poverty guidelines and large numbers of farmworkers lack of access to affordable health insurance.

The health and wellbeing of the MSAW population depends on their ability to access healthcare services in their area. MSAW populations often experience serious health problems including diabetes, malnutrition, infectious diseases, pesticide poisoning, and injuries from work-related machinery.<sup>xxiii</sup> It is necessary for farmworkers to have easy access to health care, yet it seems that mere access to clinic is an ongoing problem for significant numbers of US farmworkers. The *Promotores* Program has been established as a vital means to reach farmworkers where they live and work. It is widely accepted that rural populations face a variety of health disparities that complicate access to care, and that promotores are well-equipped to address rural health access issues, provide education, and ultimately assuage health disparities.<sup>xxiv</sup> Drawing on ethnographic data, promotores have been shown to connect structurally vulnerable clients in rural areas to resources, health education, and health and social services. promotores receive ongoing training, including at least 40 hours of initial training along with continued education to keep up their skills and learn new ones to pass on to the community. In addition, promotores are essential intermediaries (and are in many ways first responders) to the needs of rural MSAW populations. Previous studies have confirmed that including promotores results in positive health outcomes and cost-effectiveness of these workers within rural communities. For example, promotores have been found to have effectively reduced the impacts of type-2 diabetes and improved health education among a sample of Mexican American farmworkers in Texas.<sup>xxv</sup> Moreover, in response to the COVID 19 pandemic, promotores were essential in reducing negative health behaviors and dispelling myths that detrimentally affected rural populations.<sup>xxvi</sup>

### ***Recommendation III – Addressing the Unique Needs of Indigenous Agricultural Workers***

Indigenous Mexicans are the fastest growing farmworker population in the United States. Studies estimate that up to 40 percent of Oregon’s 174,000 farmworkers and families are indigenous.<sup>xxvii</sup> California has approximately 165,000 indigenous farmworkers and family members of Mexican origin.<sup>xxviii</sup> There has been a surge of indigenous Mexicans into the U.S. food system since the early 1990s, which depends on newly arrived groups of workers to maintain wages and working conditions at the entry level in the farm labor market. They perform the most arduous agricultural tasks. However, the inability to gather information about the indigenous population has led to widespread lack of awareness of this community’s needs; and, in some cases, service providers may even be unaware of the community’s existence.<sup>xxix</sup> Moreover, health care providers more often than not face the challenges of serving a population that they are not culturally competent to serve. These issues may be even more pronounced during the ongoing COVID 19 pandemic. The COVID 19 Farmworker Project, undertaken by a coalition of researchers and community-based organizers from across California, Oregon, and Washington, reiterated that the indigenous farmworkers fared worse during the COVID 19 pandemic in comparison to the Spanish speaking majority.<sup>xxx</sup> It is imperative, then, that the unique occupational and health conditions of this fast-growing segment of agricultural workers be addressed.

#### **The Council recommends the following:**

1. CDC, Deployment Globally Mobile Populations Team, Global Migration Task Force and DOL, Employment and Training Administration, Farmworkers Program collaborate to ensure that indigenous farmworkers:
  - a. Receive the appropriate culturally appropriate services, informational materials, and training in languages they are fluent, to protect themselves from the adverse health effects of pesticides and other agricultural environmental hazards.
  - b. Have access to hotlines aligned with state and regional Departments of Public Health that are staffed by individuals who are from farmworker communities to support violations’ reporting and streamlining access to critical information.
  - c. Have policy-based support from DOL address issues such as pesticides, field sanitation, problem solving, and community advocacy.
2. *HRSA conduct a needs assessment to assess the unique needs of indigenous farmers, a rapidly growing but underserved population, and establish coalitions to address health and accessibility gaps, i.e., identify location, numbers, and languages of indigenous agricultural workers.* Lead the development of health and welfare videos and glossaries, visual workshop resources at a primary education reading level in indigenous languages, such as Nahuatl, Triqui, Mixteco, Zapoteco, among others from Mexico and Guatemala.
3. *HRSA, BPHC, Primary Care Associations collaborate with local and state health departments, M/CHCs, growers and agribusiness stakeholders and farmworker representatives to develop a comprehensive strategy at a state and regional level, to better identify and serve indigenous farmworkers.* The strategy must include:
  - a. Creating community programs to educate the local receiving communities about indigenous farm working populations, their culture, history, and challenges, in order to address stigma.
  - b. Education and training of M/CHC workforce to create an awareness that indigenous languages are not a variation of Spanish, and that indigenous cultures have traditions distinct from other Latino communities.

- c. Development of a training program and cadre of indigenous community health and medical legal workers.
  - d. Supporting local capacity to communicate consistent, culturally, and linguistically appropriate public health and safety messaging, which meets the diversity, inclusion, and equity, considers the needs of non-English/Spanish speakers using more audio-based tools. Recognize that input from indigenous groups is an important part of the process of producing materials and programs to serve them.
4. *BPHC HCP consider advancing indigenous farmworker health by collaborating with the community-based organizations affiliated with the indigenous farmworker community to empower and fund the local communities develop capacity for new access point of care to meet the unique needs of this community.*
  5. *BPHC HCP National Training and Technical Assistance Partners:*
    - a. Train all M/CHC staff including front desk and providers at all levels to be curious about the person they are helping to understand their life/work context.
    - b. Collaborate with local community-based farmworker-serving organizations, and clinics to hire and train more linguistically and culturally competent staff.
    - c. Identify and train local indigenous community health and legal workers to be fully employed by M/CHCs.
    - d. Strengthen and develop workforce and technology to provide access to preventive and primary care to be brought to remote rural and urban areas through telemedicine.
    - e. Fund mobile primary care and mental health service units for MSAWs, to provide emotional support and promote psychological health.
    - f. Implement innovative solutions for the provision of immunization and pharmacy services to break down barriers to adequate treatment.
    - g. Provide linguistic and culturally sensitive training to existing CHWs/promotores serving indigenous agricultural workers. Require flexibility on the times they offer services to the community.
    - h. Support this effort to provide greater access to care for indigenous MSAWs by:
      - i. Developing workshop resources that are visual in nature and at a primary education reading level.
      - ii. Working with translators from the community to account for linguistic and cultural nuances and ensure accurate translations.
      - iii. Ensuring that materials do not perpetuate stereotypes and include input from indigenous community when producing materials and programs to serve them.
      - iv. Formatting resources so workers can easily access and carry resources in agricultural settings.

## **Background**

Migration is one in a series of processes producing structural vulnerability in health and is a core determinant of health and wellbeing. Additionally, many people receive differential treatment based on their migration status.<sup>xxxix</sup> The National Agricultural Workers Survey (NAWS) data estimates indicate that the proportion of indigenous southern Mexicans has quadrupled in less than 20 years. Eighty percent of them come from Oaxaca, and ten percent from Guerrero and other states in Mexico. Linguistically, over half are Mixtec speakers, about a quarter speak Zapotec and one in ten speaks Triqui. Indigenous agricultural workers have lower incomes and worse working conditions, fewer assets, speak less English and Spanish, and are more frequently separated from their family residing in Mexico, compared to the mestizos (Spanish speaking). The Indigenous Community Survey (ICS)<sup>xxxix</sup> indicates indigenous farmworkers employed by farm labor contractors (FLC) suffer poorer working conditions, compared to growers. FLCs pay by piece rate more frequently than growers; often charge their workers for equipment; and require payment for rides more often than growers.

Indigenous farmworkers access health care at rates far below the general population and decidedly lower than other Mexican-origin farmworkers. Insurance coverage for indigenous adults is extremely low, even when compared to the already-low rates for Mestizo farmworkers. High cost of care and lack of insurance coupled with systemic obstacles such as lack of transportation, inconvenient clinic hours, long waits, rude treatment by receptionists and staff, and fear related to immigration status, are not the only barriers to care. Linguistic and cultural barriers breed distrust and avoidance of seeking care and non-compliance with prescribed treatments. Even when an interpreter is available there may not be a vocabulary in Mixteco for medical conditions such as asthma, tuberculosis, anemia and diabetes. In women's health, there is often inadequate terminology pertaining to the reproductive system, and related procedures. This is further complicated by cultural barriers to discussing matters related to sexuality and reproduction, particularly with male providers. With the high cost of health care in California, the lack of insurance, the multiple barriers, and preference for care in Mexico or from a traditional healer, the indigenous tend to seek biomedical care only as a last resort.<sup>xxxix</sup> Gaining a sense of an indigenous person's belief system and worldview can help us understand why indigenous patients avoid modern medical care, and why they often do not comply with the prescribed treatment.<sup>xxxix</sup>

As indicated in an earlier part of this letter, the testimonies received during the NACMH May meeting the common themes expressed by testifiers included anxiety, fear, uncertainty, unfairness, equality, insecurity, structural barriers and injustice. One of the testifiers, a native of Oaxaca, Mexico, with a Mixtec dialect shared a firsthand unfortunate experience resulting from language barriers. We do not know the full extent of how delayed care based on the language barrier and other access issues contributed to his colleague's death. However, the lack of interpreters, scarcity of health care services in rural areas, absence of technology to make care accessible, and the lack of medical insurance to cover the costs of their treatment were key factors in the tragic situation.

Oregon's farmworker population experienced disproportionately higher rates of COVID 19 infection than people from other ethnic backgrounds and employment industries. The Oregon Farmworker Study<sup>xxxv</sup> states that farmworkers that identified as Indigenous to Mexico and Guatemala, had more pronounced economic difficulties paying for basic expenses, at higher rates than farmworkers that did not identify as Indigenous. The needs of this segment of farmworkers and their growing numbers and importance in the agricultural workforce demand the development of appropriate services and materials for indigenous farmworkers, to protect them from preventable exposures.

During the NACMH May meeting, many areas of concern also lead to a discussion on the how the Bureaus Operational Site Visit could be a tool to further hold MHCs accountable for how they identify, track and deliver services to MSAWs. It is recommended that the Site Visit Protocol continue to be used as an assessment tool to engage the board of directors on all levels of delivery of care of services provided to this vulnerable population.

In closing, it is with great honor that we serve on a committee that seeks to improve the health opportunities of our MSAWs across the US. The Council recognizes the role agricultural workers play in our economy, more so recognized during the pandemic that our MSAW's are essential. We thank you, Secretary for your service, and for consideration of these recommendations on behalf of those, we serve.

Sincerely,

/Sharon Brown-Singleton, MSM, LPN/  
Chair, National Advisory Council on Migrant Health

cc:

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