

Leaders



We are witnesses
2021-2022



Passionate

Dynamic



Committed



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Acknowledgments

To the team that makes up the MSAW program for the great commitment and incredible work carried out during the last year and a half!

Special thanks to the Health Promoters and Coordinator of this project for going the extra mile!

We also thank Washington Women's Foundation for financial support!

To the talented student interns for their contributions!

To the medical staff for spending time-sharing their experiences serving the agricultural community in Skagit and Whatcom counties!

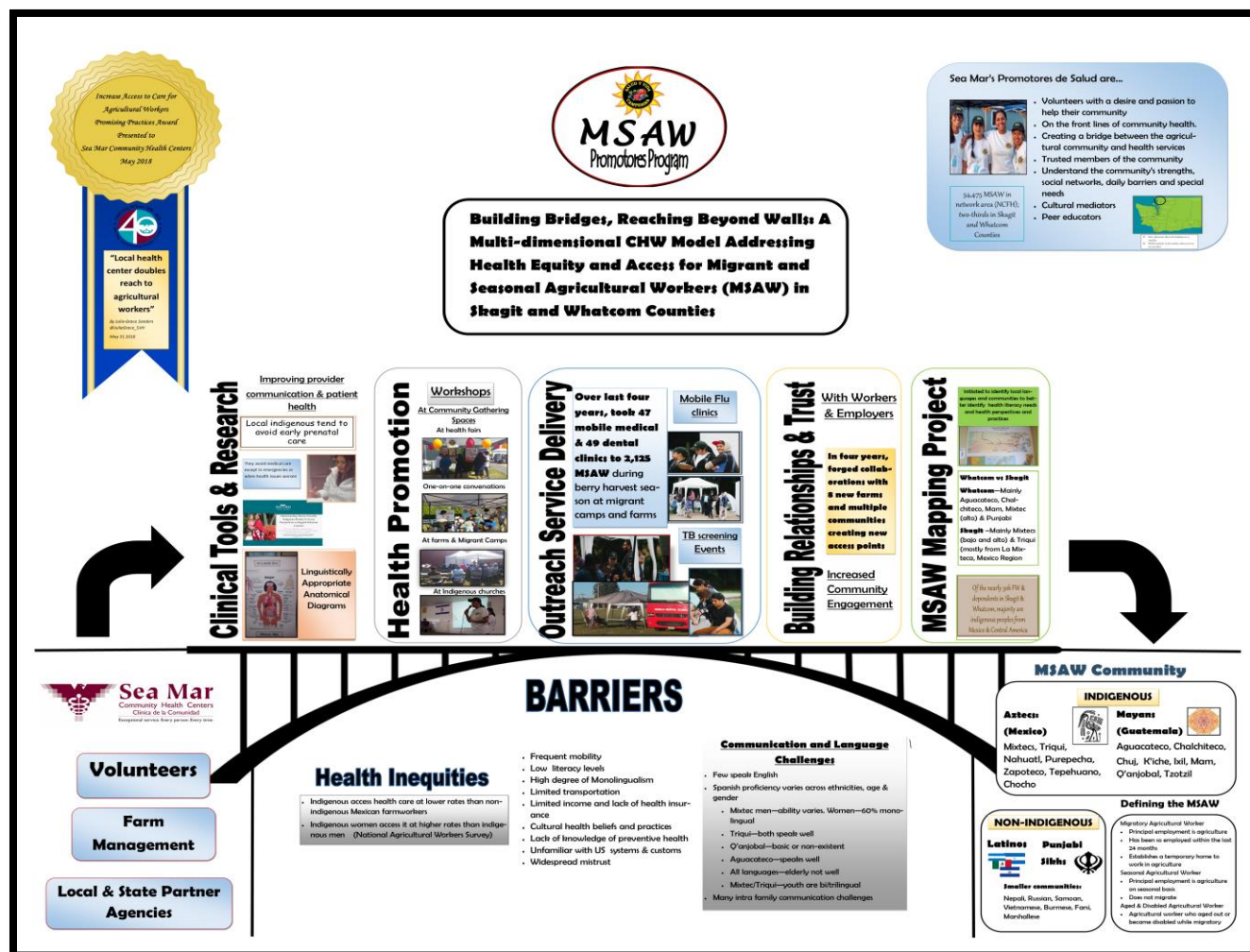
To the farmworker community of Skagit and Whatcom counties for their participation in this project and for their hard work!



MSAW Promotores de Salud Program
June 30th, 2022

Introduction

The Sea Mar Community Health Centers Migrant and Seasonal Agricultural Workers (MSAW) Promotores de Salud Program is a multidimensional model of community health workers that invests all its efforts and resources in building an environment of trust with the farmworker community in Washington State's Skagit and Whatcom counties. Promotores de Salud (community health workers) are the front line of this program and act as a bridge between community organizations and the farmworker community by opening access to medical, dental, and mental health services as well as health education/information particularly relevant to this population. This program also addresses the needs of the farmworker community; empowering them to overcome the unique barriers, they face.



Skagit and Whatcom counties are home to the majority of Northwest Washington's farmworker population, which comes from Mexico and Guatemala (NCFH, 2017). Nearly 60% of the farmworker population in the two counties belong to indigenous communities from Mexico and Guatemala. The program recognizes that these farmworkers experience more challenges and barriers than other communities in accessing information and resources.

The MSAW program reaches farmworkers throughout the year. Some programmatic activities are linked to the berry harvest season, which is normally from June to September. The Program organizes and runs mobile “health fair” clinics at migrant farmworkers’ temporary housing locations, where the majority of migrant farmworkers live temporarily and/or work on the northwestern side of Washington State. During the rest of the year, the Program's outreach focuses more on health promotion activities that include, among others, door-to-door service information dissemination, health workshops, tuberculosis screenings, and tuberculosis and flu vaccination clinics.



<https://www.mapsofworld.com/usa/states/washington/washington-county->

Objective:

Comprehensively document and share the cultural background, worldview, barriers, needs, and strengths of the farmworker community living and working in Skagit and Whatcom counties. Build knowledge bridges for local organizations and agencies to adjust and/or

create tools and systems that help them effectively deliver services, reaching the local farmworker community in a culturally appropriate manner.

Mission:

Design, development, and implementation of a Social Determinants of Health (SDOH) survey to identify the health status and level of well-being of indigenous and non-indigenous farmworkers working and living in Skagit and Whatcom counties, to create changes within organizations that are committed to reaching this community with empathy, equity, dignity, and respect.

The Promotores de Salud Program recognizes the need for responsible research regarding this population. In general, with few exceptions, research has not prioritized the study of this community locally (Skagit and Whatcom Counties) and few resources currently exist to guide organizations and institutions about how to improve services for this community that faces a unique set of needs and barriers. It is vital that migrant and seasonal farmworkers who live and work in Washington State receive fair and equitable treatment and care. The objective of this long-term research is to improve the quality of life and well-being of agricultural workers and develop tools to mitigate the impact that some social determinants of health have on their lives, creating situations of disadvantage that result in disappointing health outcomes.

Methodology**Initial steps of the Social Determinants of Health Project**

In November 2020, the MSAW Program staff began the design of the action plan for the construction of the SDOH project. This project had four main components, which included interviews with providers and nurses, secondary data collection and analysis along with the construction of an interactive online map; carried out by interns, the design of the Social Determinants of Health (SDOH) survey, and the planning and design of the delivery method for all the information generated by the project. In this project, 10 Promotores de Salud, 3 Community Health Workers, 3 staff members, and 4 university interns participated.

Interviews with providers and nurses

Two types of interviews were designed; one with questions addressed to health providers and the other addressed to nurses (see Annex A and B). A faculty member who is part of the University Of Washington Bothell School Of Nursing and Health Studies and also the Department of Occupational and Environmental Health Sciences at the University Of Washington School Of Public Health reviewed this research tool.

MSAW Program staff conducted 11 interviews in total: four with medical providers, five with nurses, and a health care assistant who belongs to the Mixteco community (one of the most representative groups of indigenous Mexican migrant communities in the area), and one mental health professional. All interviews were audio-recorded and transcribed. This phase of the project concluded in May 2021.

Compilation of information from the interviews

Subsequently, an analysis of all the answers was done. A report was made about the findings, common denominators, and relevant issues about the perception of the medical service provided to members of the agricultural community, barriers accessing these services, challenges of medical personnel, opportunities to improve the experience, and other information relevant to this population in the clinical environment (report in Annex D).

Interns

The MSAW Promotores Program had the opportunity to work with three students from the Health Education Program at the University of Washington Bothell. It was a 10-week internship during the spring term of 2021. Two of the interns took the lead in collecting secondary research data on topics related to health, culture, lifestyle, history, migration, and prenatal care among farmworker communities in the western United States. The third student created an interactive online map that highlights the most common migration routes for farmworkers who live and work in Skagit and Whatcom counties in Washington State. All data on the interactive map was taken from records of data collection captured by the MSAW Promotores Program during mobile medical and dental clinics at farms in Skagit and Whatcom counties.

A Bellevue College Arts and Sciences Program intern supported the SDOH Project for 10 weeks during the winter quarter of 2022. This intern summarized all secondary data items collected by past interns and created short blog posts from their summaries. In addition, the intern began to design an interactive delivery method where the information contained in this report is classified by categories (this project is still underway).

SDOH survey design

Social determinants of health (SDOH) are the conditions that exist in the environments where people are born, grow, live, learn, work, play, and develop their beliefs and age, conditions that affect the results and risks of health, functioning, and quality of life of an individual. Based on the SDOH definition, the MSAW Program staff decided to design a survey based on these determinants, directed to farmworkers who live and work in Skagit and Whatcom counties.

The SDOH survey had three revision drafts before the final version. The Promotores de Salud of the MSAW program piloted the first revised draft in July 2021 to make changes and adjustments. In the first draft, all categories of the SDOH Survey were finalized, resulting in 10 categories: Demographics, Education, Economy and Resources, Transportation and Housing, Eating Habits, Health and Lifestyle, Mental Health, Substance Use, Safety, and the COVID-19 Pandemic. The survey included 58 questions, 16 combined open-ended and multiple-choice questions, seven open-ended questions, and 35 multiple-choice questions (see Annex C). The second and third revisions of the survey were made due to some questions that the Promotores mentioned in general were not fully understood by the participants and for these reasons, it was necessary to add clarifying response options about services available for children under 18 years of age (demographic category).

Before implementing the survey in the community, the entire MSAW Program team, (the Promotores de Salud and staff members) received training on how to conduct the survey, reviewing question after question.

A total of 305 surveys were conducted, with migrant farmworkers and those who live in the area year-round (also known as temporary or seasonal workers), between July 2021 and

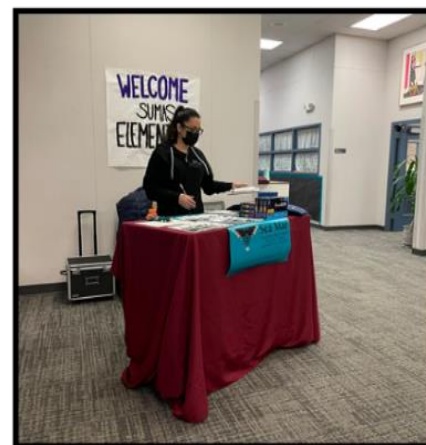
January 2022. Surveys were conducted in spaces where farmworkers work, live, shop, and receive social and health services. These locations were Temporary Field Housing at Sakuma Brothers Farm, Crystal View Berry Farm, Hayton Farms, and Sarbanand Farm; at the facilities of Skagit Horticulture, Washington Bulb, and processor Sono Inc.; during community events of the school districts and the Mexican consulate. Also at vaccination drives in Skagit and Whatcom counties, churches in both counties; Market La Gloria Latino stores in Bellingham and Everson, Net Market & Bakery, Mi Rancho Meat Market, Tacos California, Laundry Enterprise, and door-to-door visits in Latino neighborhoods in Skagit and Whatcom counties.



Latino stores



COVID-19 vaccination events



School district events



Production plants



Farmworker housings

Classification of the Worker and the Agricultural Industry

Under the National Center for Farmworker Health (NCFH):

- A migrant farm worker is a person whose main job is agriculture, employed in the last 24 months, and who has established a temporary home for the purpose of working in agriculture.
- A seasonal farmworker is a person whose main job is agriculture, employed in the last 24 months, and who has not established a temporary home to work in agriculture.
- All family members living under the same roof are classified the same as their farmworker relative.

“The Ag Worker Identification Front Office Reference Sheet is a tool designed to help health center staff ask the right questions to accurately identify, classify and report Migratory and Seasonal Agricultural Workers (MSAWs) in the Uniform Data System (UDS). It also helps to illustrate the tasks and industries included in HRSA’s definition of agriculture, as well as provide general guidelines for proper classification and reporting of MSAWs in UDS” (Ag Worker Identification Front Office Reference Sheet, 2020).

The information provided on farmworker classification identification is referenced to provide further insight into the language we use regarding the words "migrant and seasonal." For organizations that are not under the umbrella of health centers, these classifications do not apply. It is also important to note that in our direct interaction with people who work in the agricultural industry we never refer to them with these classifications; these classifications are for internal use only.

Of those surveyed, 71% were temporary agricultural workers and 29% were migrants.

The agricultural industry

These are the industries that are included in the definition of agriculture: Crop Production and Animal Production, including aquaculture, and Support Activities associated with these industries. (Ag Worker Identification Front Office Reference Sheet, 2020).

food in the market. This meant that the U.S. had to develop an idea to rapidly increase food production for its residents and keep its economic growth stable in the agricultural sector, but also maintain a wage that allowed for higher profit margins.

The Mexican Braceros program was the ideal solution and was better suited to the U.S. than to Mexico. For U.S. agricultural employers, it created more jobs so there would be an increase in bracero workers, which in turn would increase the crops planted. The increased production of vegetation and food with low-cost labor meant that there would be an increase in profits. For the bracero workers, although they were poorly paid, they settled in the U.S., as it was a better opportunity for stable income than in Mexico.

The Braceros program ended up being a crucial factor in the peak of legal Mexican immigration in 1956. Most of these people could not speak or understand English. Some indigenous workers who were part of the program, such as the Mixtecos, could not converse in Spanish or English, but only knew their native indigenous language, Mixteco (Geyman et al., 2012). Since there was a huge communication gap and most legal Mexican immigrants had only minimal exposure to agriculture, the U.S. farm

owners encouraged them to come and work for them, mainly because they were able to maintain higher profit margins and pay them very well below the minimum wage. Shortly after the Braceros program ended, adding an estimated 1.5 million to 2 million migrant workers, indigenous communities, such as the Mixteco from Oaxaca, began migrating without any documentation, for a better life and opportunity (Martin, 2020). There was an increase in the pace of Oaxacan migration doubling from 6.1% in 1996 to 11% in 2000 (Mixtec.org). With such intense immigration and migration in the 20th century, people of color, especially Latinos and Hispanics, were dominating agriculture.

On September 6, 2001, then-President George W. Bush and the President of Mexico, Vicente Fox, reached a consensus on immigration and temporary labor reform for Mexican migrants (Waslin, 2003). However, after 9/11, these reforms were set aside and security on the U.S.-Mexico border increased instead.

Previously, between the 1980s and 1990s, indigenous populations began to migrate seasonally to the states of California and Washington to collect berries and return to Mexico in the winter months (Holmes, 2013). With the increased militarization of the U.S.-Mexico border after 9/11, a program called Prevention Through

Deterrence placed security in safer regions to cross. Consequently, immigrants are forced to cross more dangerous areas of the desert facing extreme heat, dehydration, scorpions, rattlesnakes, and other non-climate or non-animal hazards. Some people have dedicated themselves to committing criminal acts such as robberies and rapes against those who travel these paths to cross the border. Some decide to stay in the United States because of the risk of death in the less protected parts of the border. In these cases, many workers financially support their relatives in Mexico from a distance (NFMW, n.a.).

After the events of September 11, Mexican migrants also have difficulties obtaining identification documents and lacked labor rights (Waslin, 2003). These policies primarily influence the time that migrants spend within the United States, also part of their migratory history.

Employers also have the right to fire workers if they identify them with false documents. This was after the Hoffman Plastics v. National Labor Relations Board (NLRB). There is less liability and more advantages for employers to hire undocumented workers because they are not responsible for their unauthorized status.

Migration

To give some background, Oaxaca and Guerrero are the states of origin of the Mixteco, Triqui, and Zapoteco communities. Traditionally, families grow corn, beans, and green leafy vegetables (Holmes, 2013) (Geyman, et al, 2012). The main objective was to grow corn to sell, since it was their main crop, and to maintain the land. However, around the 1990s, after the increase in the production of low-cost, foreign-grown corn and the signing of the North American Free Trade Agreement (NAFTA), incomes for local populations were affected. NAFTA was a signing between the U.S., Canada, and Mexico that prohibited tariffs on goods imported and exported between the countries. In a survey of Mixtecos in Washington, all 38 people interviewed said they migrated due to a lack of job prospects and financial difficulties in Mexico (Geyman, et al, 2012). Additional economic hardships include crop failure, soil erosion, and water scarcity.

The Mam community traditionally did seasonal jobs picking bananas and coffee in southern Guatemala. Unfortunately, that land is no longer cultivated, however, the population continues to grow and the level of poverty increases. Therefore, the seasonal income is not enough for the year and some

migrate to the United States for work. Farmworkers from the Mam community, in particular, work in the flower bush industry. As a result, the need arose for at least one member of the family to find work elsewhere by migrating to the capital of Mexico and/or crossing the border (Ortiz, n.a).

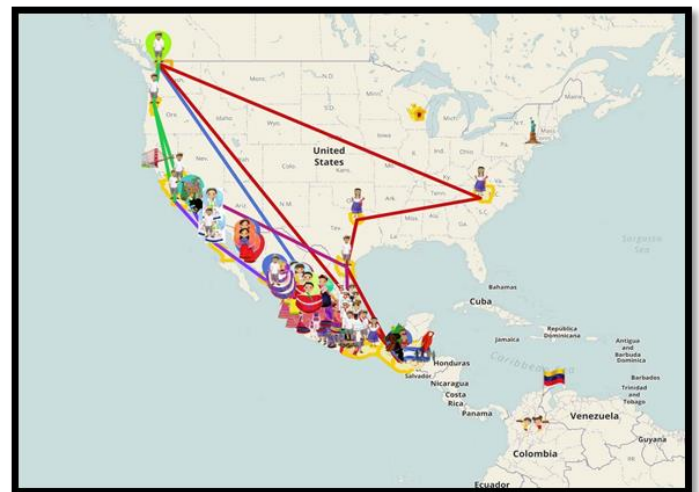
Migration for many indigenous populations is not static but changing. Most of the time, indigenous people migrate for farm work in different like California, Oregon, Arizona, Washington, and sometimes Idaho (Ortiz, n.a). Seasonal farmworkers are those who stay in a region, while migrant farmworkers migrate between states. Although policies make

crossing the border dangerous, farmworkers occasionally migrate back to Mexico. Agricultural work can include a variety of products, such as berries, orchard picking, and vegetables such as sweet potatoes and potatoes, depending on the season (KBCS, 2017).

The migratory routes of women can be both within their native country and toward the United States. Marriage, family difficulties, and children greatly influence the migratory routes of women. Men are more likely to follow migration routes to the U.S., although women also migrate, most often with a family member (Ortiz, n.a).

For more information on the common migratory routes of farm workers arriving in Skagit and Whatcom counties, and to recognize the place of origin of the respondents, visit:

[https://maphub.net/atrue99/msaw-interactive-map-project](https://maphub.net/atrue99/msaw-interactive-map-projectinteractive-map-project)



Indigenous communities of Mexico

Over the years, the MSAW Promotores Program team has witnessed that farmworkers who are part of indigenous communities are culturally different from non-indigenous farmworkers. The Mexican states of Oaxaca and Guerrero have a culture very different from the culture of the rest of the states of Mexico due to their high concentration of indigenous communities. The ten states with the highest proportion of reported national indigenous population are Oaxaca (18.3%); Veracruz (13.5%), Chiapas (13%), Puebla (9.42%), Yucatán (8.2%), Hidalgo (5.7%), State of Mexico (5.6%), Guerrero (5.2%), San Luis Potosí (3.2%) and Michoacán (2.9%). In terms of relative presence, the Mexican states with the greatest presence of indigenous languages are Oaxaca (with 52.7% of the state's population) and Yucatán (52.5%)” (Fox, 1999).

In Skagit County in the state of Washington, the indigenous farmworker communities are mostly Mixteco from the Mexican states of Oaxaca and Guerrero, and Triqui from the state of Oaxaca. These two indigenous communities have added to Skagit County the richness of their culture; establishing restaurants, stores, churches, and of course their families.



Mixteco



Flickr/ Thomas Aleto

Mixteco



Flickr/ Thomas Aleto

Triqui



Triqui



Flickr/ Thomas Aleto

Indigenous communities of Guatemala

Guatemala is home to 24 ethnic groups, it is estimated that it has 6.5 million indigenous inhabitants that constitute approximately 43.75% of the total population (IWGIA, 2022). There are 22 Mayan groups that include: Achi', Akateco, Awakateco, Chalchiteco, Ch'orti', Chuj, Itza', Ixil, Jacalteco, Kaqchikel, K'iche', Mam, Mopan, Poqomam, Poqomchi', Q'anjob 'al, Q'eqchi', Sakapulteco, Sipakapense, Tektiteko, Tz'utujil and Uspanteko, in addition to the Garífuna, Xinca, and Creole or Afro-descendant peoples. (IWGIA, 2022).

The predominant Guatemalan indigenous community in the area is the Awakatekos, who come from the departments of Huehuetenango and Chimaltenango, however, 3 other communities live and work mainly in Whatcom County: Chalchiteco, Mam, and Canjoval.

Guatemalan indigenous communities have only recently settled in the area, unlike Mexican indigenous communities that have migrated for decades, settling widely.



Mam



Radio B'alam

Mam



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Canjoval



Awakateca



Awakateco

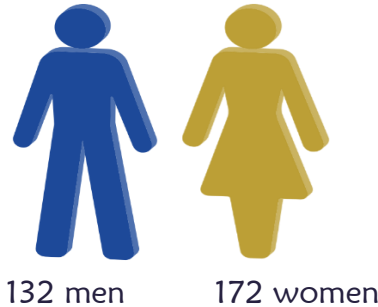
Chalchiteca



Survey Findings

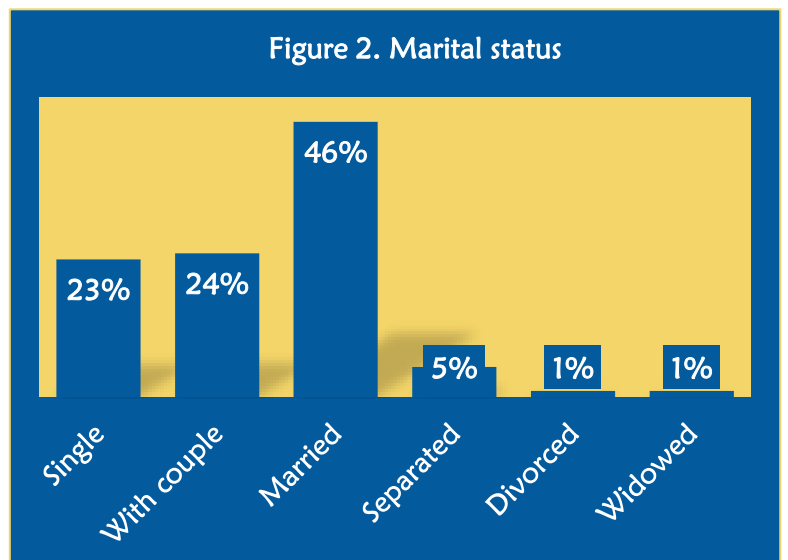
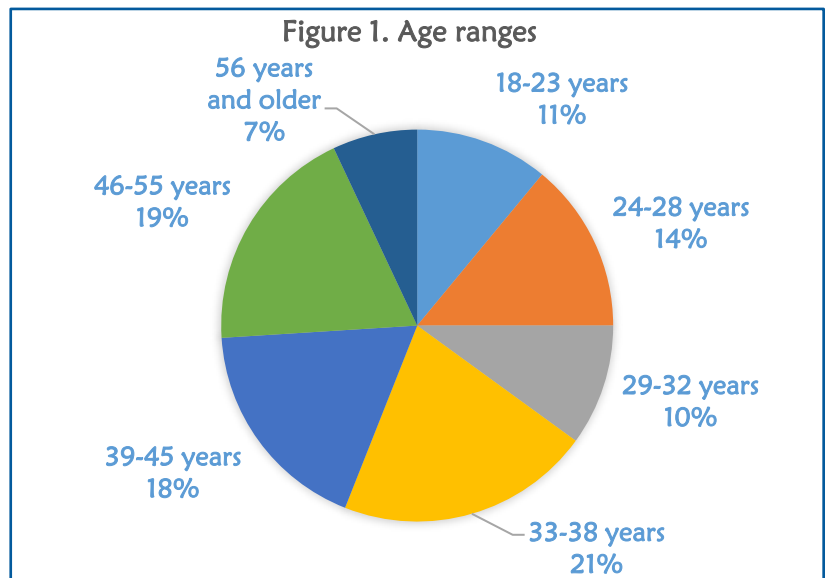
Demography

Of 305 participants, 132 were men and 172 were women, 1 preferred not to answer



Cultural traits related to age

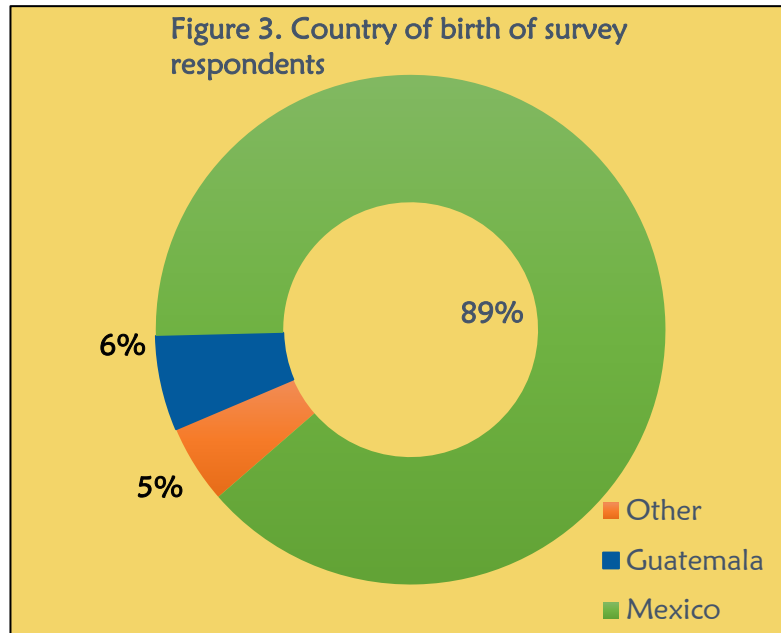
In some of the local indigenous communities, a woman who has not married after the age of 20 is called an “abandoned woman” which means that she is no longer going to marry and perform the role of wife and mother. This view is due to the custom that women need to get married and have children before age 20. Culturally, women under the age of 18 are considered *pure*, and this is the age at which they should marry. The woman loses value after 20 years of age from the point of view of the community. When a woman marries after the age of 20, normally her husband could be a widowed, elderly, or separated man. However, after living for a few years in the United States some families have changed their perspective on this, understanding that the role of women transcends beyond being a mother and a wife.



Note: The working communities of the countryside identify living together with another person without being married with the words “being together”/ “estar juntados”

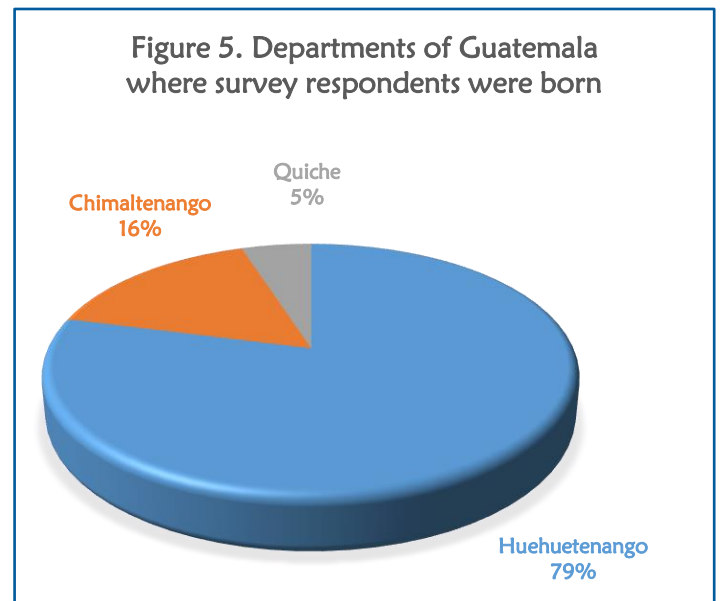
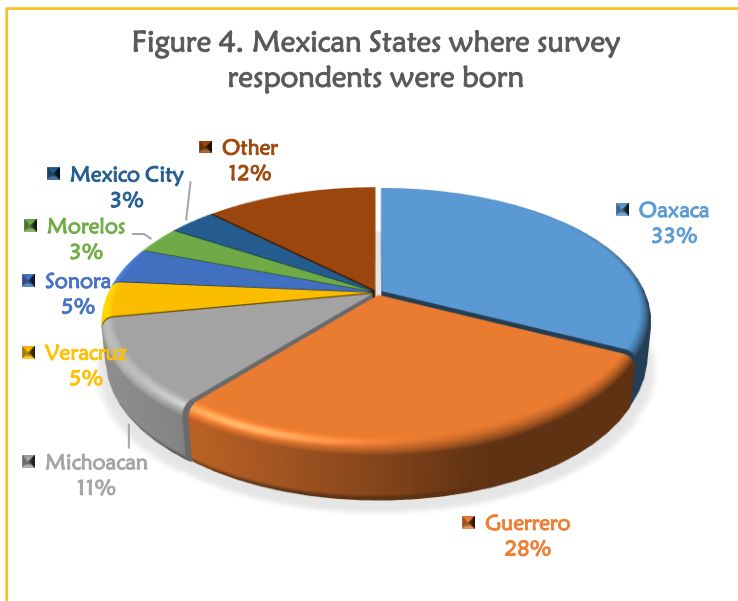
Eighty-nine percent of those surveyed were born in Mexico, 6% in Guatemala, and 5% in another country: El Salvador, Venezuela, Honduras, or Colombia.

Most of the respondents who reported being from Mexico are from the states of Oaxaca (33%) and Guerrero (28%) (see Figure 4.). 79% of the respondents who reported being from Guatemala are from the department of Huehuetenango.



The majority of the nearly 30,000 farmworkers in Skagit and Whatcom counties are from

Mexico, with a high proportion (60%) of indigenous people from the rural southern states of Oaxaca and Guerrero, and Guatemala. In Skagit, most of the indigenous people speak the Mixteco and Triqui languages. In Whatcom, the majority are Mixtecos and at least five different Guatemalan cultural communities (Awakatecos, Mam, Chalchiteco, Ixl, and Canjovál). The MSAW Program continues to discover new communities regularly, so this is just a snapshot. We know that some workers also speak indigenous Mexican languages other than those already mentioned: Nahuatl, Zapotec, Purépecha, and Quiché. Non-indigenous languages spoken by the farmworkers include Punjabi, Nepali, Russian, Samoan, Vietnamese, and Burmese.



Beginning in 2016, during mobile and dental clinics in migrant farmworker housing, the MSAW Promotores Program began collecting demographic information, including the range of languages spoken by migrant farmworkers coming to Skagit and Whatcom counties each year to harvest berries.

The indigenous Aztec and Mayan languages of Mexico that have been found throughout these years are:

Oaxaca	Guerrero	Veracruz	Durango	Sonora	Puebla	Michoacan	Chiapas
<ul style="list-style-type: none"> • Mixteco • Triqui • Zapoteco • Amuzgo • Mije 	<ul style="list-style-type: none"> • Mixteco • Amuzgo 	<ul style="list-style-type: none"> • Cho Cho • Chinanteco 	<ul style="list-style-type: none"> • Tepehuano 	<ul style="list-style-type: none"> • Yali 	<ul style="list-style-type: none"> • Nahuatl 	<ul style="list-style-type: none"> • Purepecha 	<ul style="list-style-type: none"> • Tzutzil

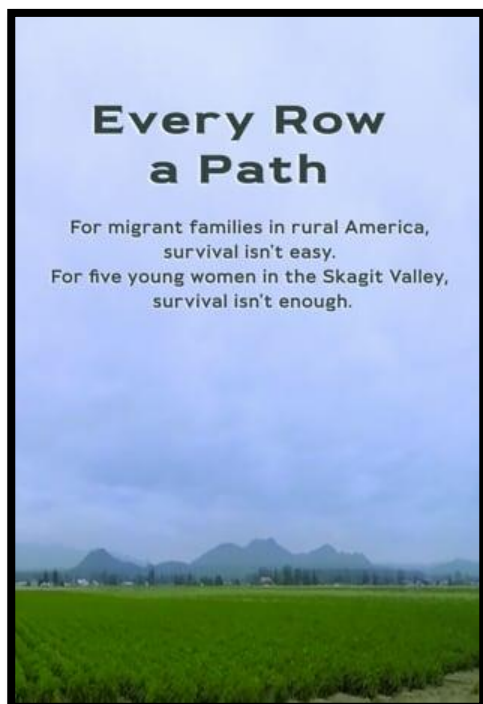
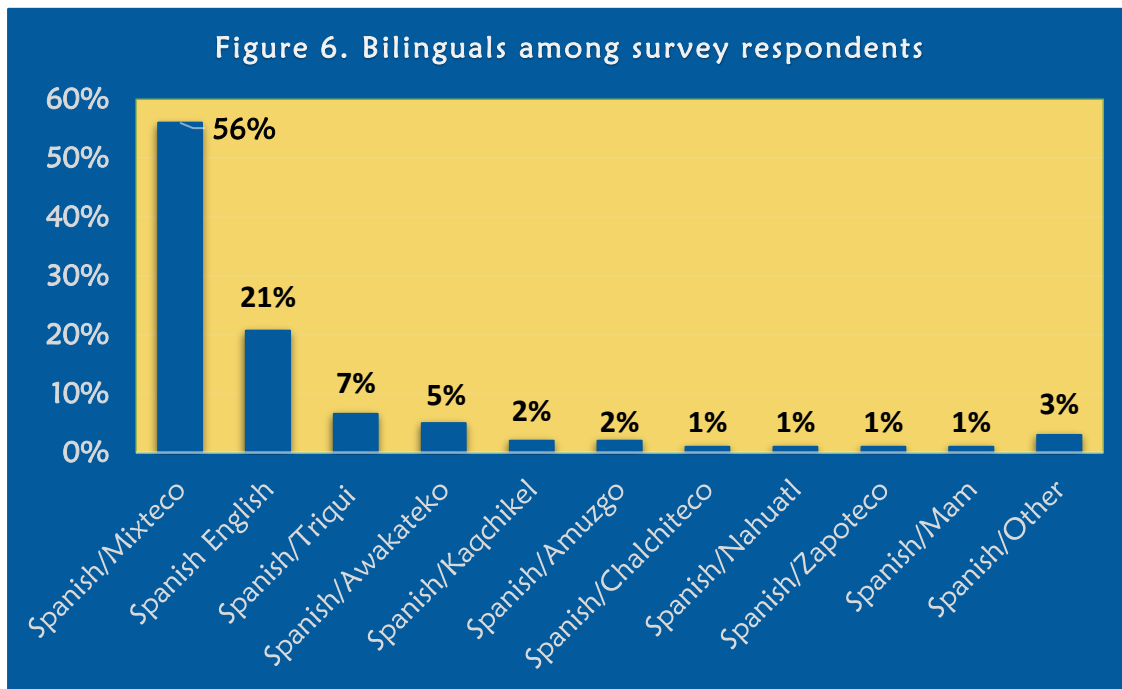
The Mayan indigenous languages of Guatemala that have been found throughout these years are:

Huatenango	Chimaltenango	Quiche
<ul style="list-style-type: none"> • Awakateco • Chalchiteco • Mam • Canjovál • Chuj 	<ul style="list-style-type: none"> • Kaqchikel 	<ul style="list-style-type: none"> • K'iche' • Ixil

For the new generations, those who presently are 20-30 years old, who migrated to the United States as children and who had the opportunity to attend school in the United States, language is no longer an obstacle; most are trilingual, with English being their second language and Spanish being their third. This generation that began to work in the fields together with their parents and did so for many years now has a different labor orientation and many of them have finished or are pursuing higher education. These are the family members who are and have been helping their parents by interpreting during medical appointments, opening a bank account, obtaining permanent housing, and helping them navigate the local

system in general. They are the cultural bridge for they are bicultural. They know and belong to one culture, but grew up in another and have appropriated and integrated both cultures into their lives. This makes them versatile and very necessary within the organizations that offer services to the indigenous communities that live in the area.

Of 305 participants in the SDOH survey, 2% are trilingual, 45% are bilingual (see Figure 6), and 8% are monolingual Mixteco & 45% are monolingual Spanish.

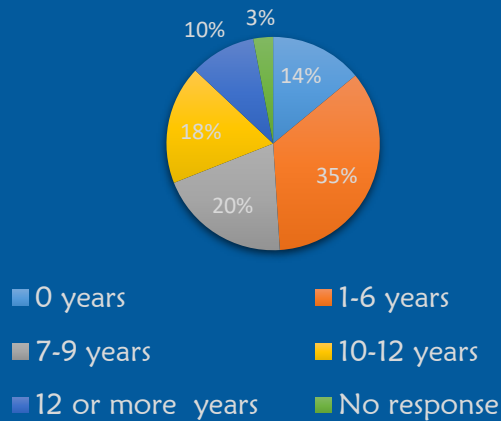


“In the berry fields of Washington State’s Skagit Valley, migrant teenage girls struggle to balance family and school with backbreaking agricultural work. Statistically, they are destined to fail, but five young women are determined to beat those odds.

Produced by the DreamFields Project, in partnership with Reel Grrls, Every Row A Path is a collaboration between filmmaker Jill Freidberg and the youth who appear in the film, providing an intimate look into the daily struggles and rewards of being young, migrant, and female in rural America.” - <http://www.everyrow.com/trailer.html>

Education

Figure 7. Level of education of the participants



Challenges faced by the farmworker community due to low literacy:

- Need more time to read and reread information before they can understand it
- Problems filling out forms, reading labels and prescriptions
- Difficulty understanding oral and written information
- The process of understanding and learning is much slower than for others.

Many organizations offer community services, however, these services are often tailored to a single community. Understanding that many communities are living in the same area and that some are the minority, but that they are growing rapidly in number, it is necessary for local organizations to adapt the services offered to these communities. The best way to start this adaptation of services is to get to know the new audience being reached, by understanding their cultural background, beliefs, traditions, barriers, needs, and preferences. Researching who the clients are and what are the best ways to serve them will help to deliver services successfully, fulfilling the purpose and mission behind each program.

Important facts about the respondents:

1. 14% are illiterate
2. 35% low level of literacy
3. Only 12% report higher education

Reading and writing in Spanish and/or native languages

It was found, through the SDOH survey, that 14% of the participants reported not being able to read or write in Spanish. Additionally, among the indigenous farmworker population, 9% reported that they could read and write in their native language, and 30% reported that they could not read or write in their native language. The members of the indigenous communities that we know who write in their native languages do so phonetically. We have seen that two or more people writing the same sentence in the same language do so differently. For this reason, written communication in indigenous languages does not help convey a clear message. Most of the members of these communities do not know the grammatical structure of these languages; which makes it not universal writing that everyone can understand.

How communication is delivered to the farmworker community, especially the indigenous community is key. Some organizations try to do written translations into indigenous languages; however, as mentioned above, most of the members of these communities who say they can write in their native language do so phonetically, which means that the way they write differs from how another can write.

Written communications in these languages should focus on universal vectors and symbols and use explanatory graphics so that anyone can understand without using words. Using familiar cultural elements further ensures that a message is understood. Also, to deliver information to the community and educate them about the services and topics relevant to them, it must be done more often verbally, if possible one-on-one, making sure that feedback is received to ensure information is delivered correctly.

The following are communication tips for organizations serving the farmworker community. Implementing these tips into your organization's protocols will help your staff be more successful in delivering your services/products to this specific community.

- Speak slowly
- Use simple, non-medical, everyday language
- Do not use acronyms
- Use photographs, images
- Limit the amount of information
- Repeat it and comment
- Re-teaching
- Create an environment free of shame
- Avoid power dynamics

Having a conversation in English and/or Spanish

Twenty-four percent (75 people) of those surveyed reported being able to have a conversation in English; however, we do not have information about how fluent these people are in English. Seventy-three percent (55 people) of those people are over 33 years old.

It is important to note that we have no information on the English fluency of those who reported being able to have a conversation in English.

It is common to find people in the agricultural community with an indigenous background who claim to be able to communicate in Spanish, however, when starting a conversation it is notorious that they cannot follow the conversation 100%. This indicates that we cannot assume that they speak a language other than their native language just because they say they can or because they can speak some words in other languages. Verbal communication should be in the person's native language to ensure information is understood.

It is important to mention that some members of the community are ashamed of their roots and this can lead them to prefer to speak Spanish, without being fluent, despite having the possibility of using an interpretation service in their native languages. As organizations, agencies, and institutions serving these communities we have a responsibility to ensure the fluency that community members can have in different languages; otherwise the result may have negative consequences for them in terms of decisions they make, documents they sign, or verbal statements they make regarding relevant aspects such as health, housing, among others.

Education among children of farmworkers

A total of 65 of 114 (57%) participants who have lived in the area for several years reported that their children over the age of 18 have completed higher education.

This shows that for the children of workers who establish a permanent home in the United States, the opportunity for their children to attend college is much greater compared to those who migrate from one place to another (migrant workers). Attending high school in the same location allows students to receive guidance and apply for scholarships with the help of counselors. The network of students growing up in one place is broader and stronger.

It is important to continue supporting programs that involve agricultural workers, both seasonal and migrant, in their children's studies. This involvement also provides an opportunity for parents to learn about the local school system and at the same time encourage them to support their children in their academic studies.

The academic growth of the children of agricultural workers contributes to the economic and social improvement of the agricultural families in the area. Likewise, as a positive consequence, involving these communities in professional fields, such as health, where they can support future generations.

Other challenges

Concepts and words that do not exist in the different indigenous languages make it even more difficult for members of these communities to process information relevant to their health.

- **9% reported that they do not know what a vaccine is**
- **23% reported that they do not know what HIV/AIDS is**

Economy and Resources

An 83% of those surveyed stated that they are currently working and 17% stated that they are not working. Of those who currently work, 71% stated that they or a family member works in the fields/crops, 18% in a processing/packing plant, 10% in nurseries/nursery, and 1% said that they worked in another job such as cleaning houses or at a hotel.

Agricultural workers are found in a variety of occupations, including field crop jobs, nurseries, livestock raising and care, fruit and vegetable sorters, agricultural inspectors, supervisors, and farm managers. Most are hourly or contract workers paid directly by farm owners, but some are employed by farm service companies, including farm labor contractors (Castillo and Simnitt, 2022).

Agricultural Activities Calendar in Skagit and Whatcom Counties		
Crop	Agricultural Activity	Time Ranges
Potatoes	Sowing	April- June
	Harvest	Agust- October
	Storage	October
	Packing	Agust- January
Cauliflower	Sowing	April-July
	Harvest	June- September
Cucumber	Sowing	May- June
	Harvest	July- October
Strawberry	Sowing	Agust
	Harvest	June
Raspberry	Sowing	May
	Harvest	July
Blueberry	Sowing	May
	Harvest	July- Agust
Early blackberry	Sowing	May
	Harvest	July
Late blackberry	Sowing	May
	Harvest	August
Tay Berry	Sowing	May
	Harvest	July

“The Skagit Valley Tulip Festival” Held annually April 1 to April 30 / Flowers Calendar	
January	<p>Bulbs: They are in the fields lying dormant.</p> <p>Flowers Fields (tulips and daffodils): They have begun to emerge from the ground.</p> <p>Flowers Greenhouse (tulips, daffodils, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow.</p>
February	<p>Bulbs: They are beginning to use their energy storage to produce a bloom.</p> <p>Flowers Fields (tulips and daffodils): The daffodils have green buds and depending on weather, may begin to be picked anywhere from mid-February to mid-March. The tulips will begin to develop a bud.</p> <p>Flowers Greenhouse (tulips, daffodils, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
March	<p>Bulbs: They are in the fields actively growing, and using energy to produce a bloom.</p> <p>Flowers Fields (tulips and daffodils): The daffodils are being picked. The tulips will be growing and the bud will begin to get larger and color as it gets closer to its average bloom time of April.</p> <p>Flowers Greenhouse (tulips, daffodils, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
April	<p>Bulbs: Tulip bulbs are using energy to produce a bloom. When the daffodil blooms die down, they are browned. This is how the daffodil stores its energy and grows the bulb once the flower has quit taking all the energy.</p> <p>Flowers Fields (tulips and daffodils): The daffodils are done being picked. The tulips will be picked in tight buds before they are visibly open and blooming.</p> <p>Flowers Greenhouse (tulips, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
May	<p>Bulbs: The daffodils bulbs are storing energy and the bulb will continue to do most of its growing. Once the tulips are fully bloomed, but before the petals start to drop off (unlike the daffodil blooms that just shrivel up and dry out), they must be “topped” by removing the bloom. This serves two purposes. 1. It prevents the spread of botrytis disease (and reduces the need for a chemical to help prevent disease), 2. It allows the bulb to immediately begin storing energy to grow bulbs. They will remain in the field growing until the first week of June.</p> <p>Flowers Fields (tulips and daffodils): The tulips are done being picked. Right before we start the harvest process, they are “chopped”. After the field flowers have been harvested, most seasonal employees will be laid off. Many move on to berry harvest. A few will opt to take a couple of weeks off and come back for bulb harvest.</p> <p>Flowers Greenhouse (tulips, lilies, peonies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
June	<p>Bulbs: Machine harvest of tulips initiates. The daffodil bulbs are now growing very large. The tulip bulbs are brought to the farm where they are cleaned, sorted, dried, and graded.</p> <p>Flowers Fields (tulips and daffodils): none.</p> <p>Flowers Greenhouse (tulips, lilies, peonies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
July	<p>Bulbs: Machine harvest of tulips will end in early July. Machine harvest of daffodils will initiate. The bulbs are brought to the farm where they are cleaned, sorted, dried, and graded. Rehiring of any laid-off field flower pickers and some new employees for the busy bulb season, which lasts a couple of months.</p> <p>Flowers Fields (tulips and daffodils): none.</p> <p>Flowers Greenhouse (tulips, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
August	<p>Bulbs: Machine harvest of daffodils ends. The daffodil bulbs are brought to the farm where they are cleaned, sorted, dried, and graded.</p> <p>Flowers Fields (tulips and daffodils): none.</p> <p>Flowers Greenhouse (tulips, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
September	<p>Bulbs: Bulbs are stored for planting. The workforce will again be reduced. The process of field bulb planting will begin again.</p> <p>Flowers Fields (tulips and daffodils): none.</p> <p>Flowers Greenhouse (tulips, lilies): We are always planting bulbs each month to go into the coolers, which will come out of coolers and go into the greenhouses to grow, all depending on the date we want to pick them. We pick, pack, and ship them daily to customers around the country.</p>
October	<p>Bulbs: Field bulb planting is underway.</p> <p>Flowers Fields (tulips and daffodils): none.</p> <p>Flowers Greenhouse (tulips, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
November	<p>Bulbs: Field bulb planting is completed, weather permitting.</p> <p>Flowers Fields (tulips and daffodils): They should be safely tucked away in the ground (after the bulb has been planted) where it spends the first half of its cycle trying to grow a flower. Once the weather cools, it will go dormant.</p> <p>Flowers Greenhouse (tulips, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>
December	<p>Bulbs: They are in the fields lying dormant.</p> <p>Flowers Fields (tulips and daffodils): Once the weather cools, they will go dormant.</p> <p>Flowers Greenhouse (tulips, lilies): Bulbs are planted to go into the coolers, which will come out of coolers and go into the greenhouses to grow. Daffodils, tulips, and lilies are picked.</p>

Of the variety of occupations in the agricultural industry, field crop workers classified as “seasonal” (reference definition on page 8) often experience fluctuations in the amount of work available to them. The berry and vegetable harvest season, known as peak season in Skagit and Whatcom counties, is typically the time when field crop workers earn the majority of their annual income and are employed. During the colder months, known as the low season, they can often find themselves unemployed. The work done in the fields during the low season is reduced to weeding, planting, pruning, watering and preparing the land, and grinding old plant residues to use as compost. To carry out these activities, the owners of the farms require much fewer people. It is above all, trustworthy people who have worked all year round and for many years on the farms who carry out the work in the low season. These people are mostly men over 35 years old.

Due to the reduction of work during the low season, many farm working families have no other choice but to work up to 18 hours each day during the high season, to save enough money to cover their expenses during the low season. During the high season, there is so much work that family activities become secondary. It is common to see that children under the age of 14 are left alone, in the care of older siblings who are also children. Teenage children over 14 years of age also work and contribute to the family economy.

During the low season, it is also common for families who live in farmworker housing year-round to obtain a loan/credit from farm owners in order to stay in a home.

It is also common to see that many agricultural workers accept a job outside of agriculture, such as collecting snow, cleaning houses, construction among others.

An 88% (205 of 232) of people surveyed with one or more children are at, or below the poverty level; 64% (149) of these reported having three or more children. Clearly, the larger the families, the more income is needed. There are usually many young children, and only parents work.

2021 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

1	\$12,880
2	\$17,420
3	\$21,960
4	\$26,500
5	\$31,040
6	\$35,580
7	\$40,120
8	\$44,660

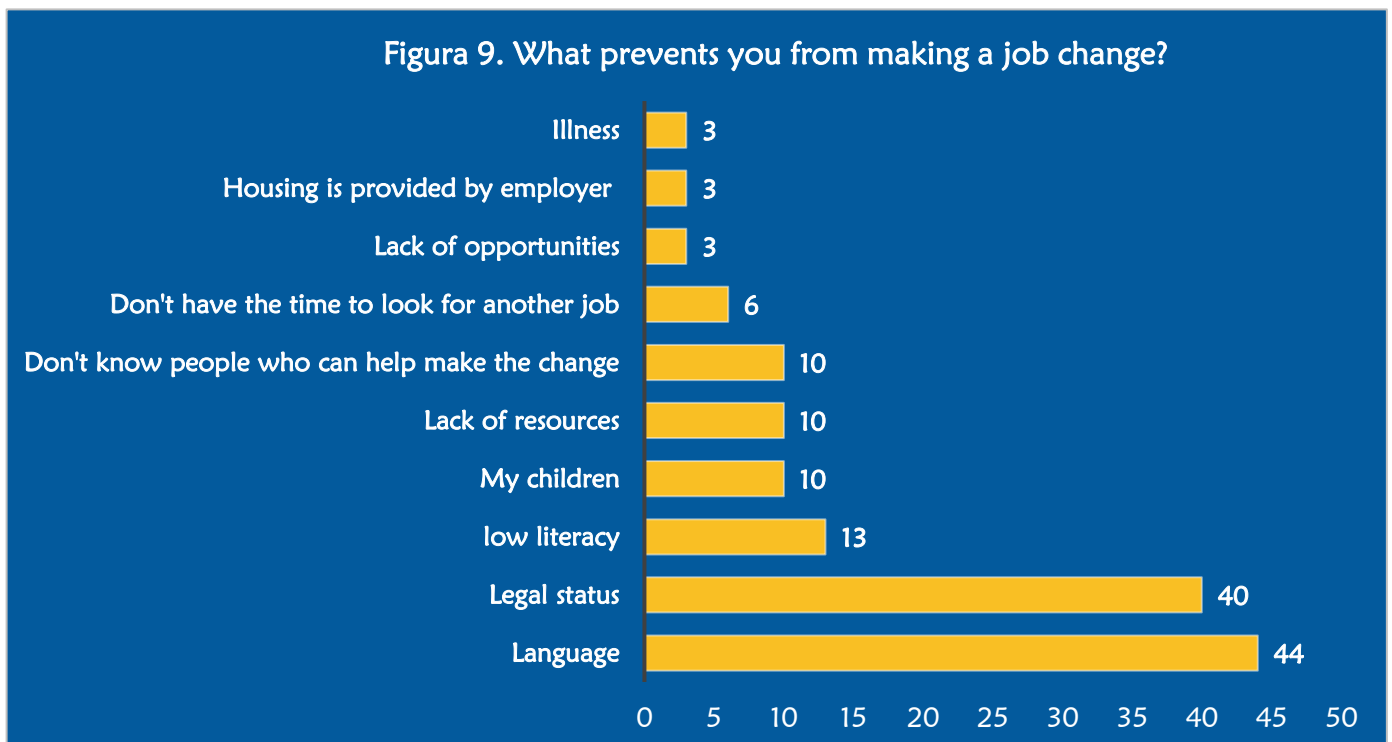
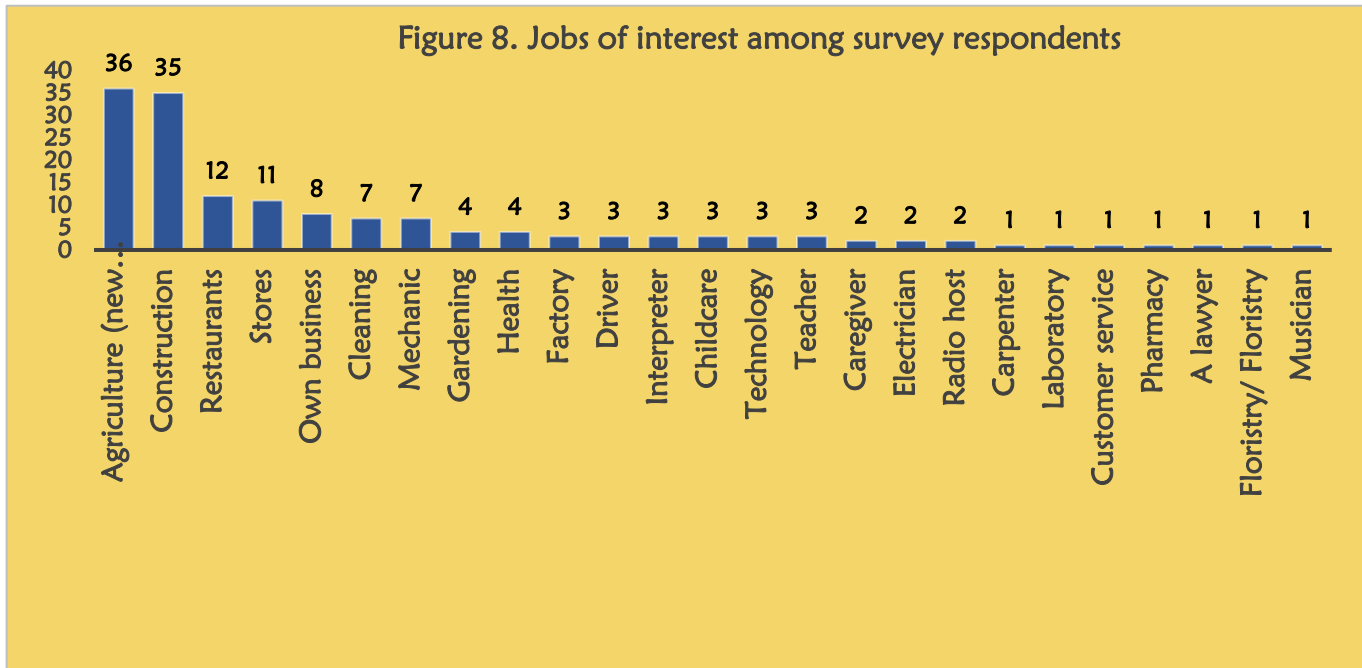
Persons in family/household Poverty guideline

For families/households with more than 8 persons, add \$4,540 for each additional person.

(Office of the Assistant Secretary for Planning and Evaluation, (ASPE), 2021)

Looking for a new future

When asked if they would like to do a job other than the one they currently have, 69% responded that they would like to do another job, 30% said no, and 1% did not answer the question.



Agricultural workers seek advancement through better-paying jobs within the agricultural industry and in other industries. Although workers want to make job changes, it is difficult to do so due to certain barriers; the most common ones mentioned by farmworkers (listed in the “What prevents you from making a job change?” table) are language, legal status, and low literacy.

Another barrier that prevents members of the farmworker community from trying other jobs, or entering other industries, is “fear”. The “fear” of trying something unfamiliar, new work environments, insecurity about one's abilities, low self-esteem, and a general hesitancy and uncertainty about exploring new ways of making a living.

Low self-esteem is marked as a prominent factor, mainly due to intergenerational trauma. For generations, indigenous communities in Mexico, Guatemala, and around the world have faced discrimination, racism, abuse, oppression, inequality, injustice, and underrepresentation (United Nations, 2011). A situation that has prevented these communities from having the opportunity to change history for their future generations.

Assistance programs

Surprisingly we can see some cases in this community where some members dare to explore new jobs and new ways of life. Unfortunately, many may experience rejection by their own families and be singled out for wanting to make a change in their lives. Many break cultural traditions or appropriate gender roles that are not accepted by the community, such as; a woman who works at night, or a single woman who wants to improve herself, and avoids marriage and children because she wants to be educated before starting a family. Multiple barriers are also faced culturally.

It is for these reasons that the agricultural indigenous community would benefit from educational and labor improvement programs for the child, youth, and adult population. These programs must be developed with the community that is to be reached in mind; culturally appropriating them.

Fifteen percent of those surveyed reported receiving Food Stamps (SNAP), 14% WIC, 3% help with the payment of housing, and 2% help with the payment of electricity.

Figure 10. In the past year, which of the following things did you need that you couldn't get?

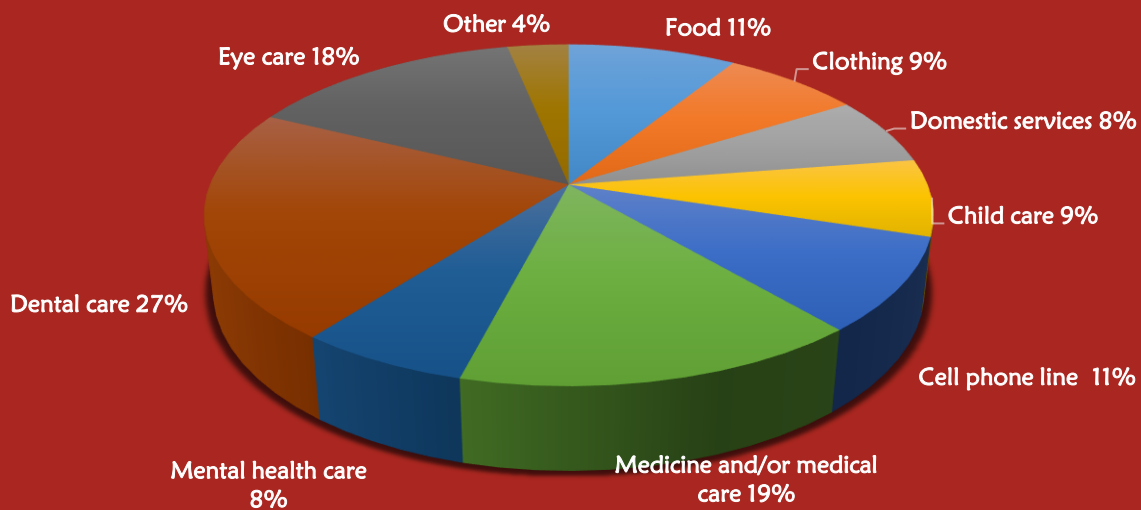
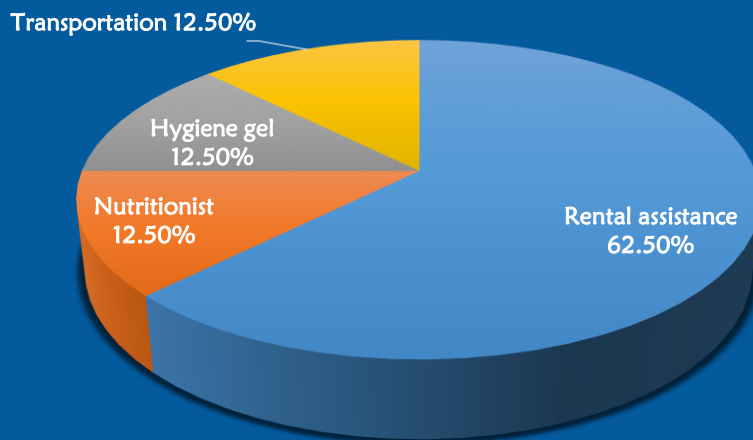


Figure 11. Other things needed in the last year



It is important to note that many families need help obtaining food. Many farmworker families, as noted above, comprise many members. With this in mind and the fact that their annual income is often at or below the poverty level, farmworker families need to be informed about local food assistance programs and food banks.

The best way to communicate to the farmworker community, especially the indigenous community, about available resources is by reaching out to their members face-to-face, verbally, in their languages, explaining the details, using simple language, with a friendly tone, without using intimidating power dynamics as this will block communication.

As community agencies offering services to the agricultural community, we have an obligation to deliver information and services ensuring that individuals can easily understand and navigate them, to fulfill the purpose that they can make use of these services and benefit from them. The more complex the system, service, or information is to navigate, understand and assimilate; the less likely it is that a member of the indigenous community will dare to use it.

Internet access

In our society, everything is communicated through the Internet, but not everyone has access to this resource or knows how to navigate it. This is of particular concern if organizations only use the Internet as their primary means of informing the community about their services. This constitutes one of the greatest challenges for the agricultural community. For example, completing an application for rental assistance online or checking the status of vaccine availability at a clinic. Options for seeking and receiving services with organizations should include a phone line with options to receive help in a language the client understands and in-person to reach all communities. Paper formats are still necessary, not everyone is ready to access documents online, much less fill them out.

Among those surveyed, 48.5% have limited internet access and 9.5% have no internet access.

Transportation and Housing

Transportation

Survey respondents reported that lack of transportation has prevented them from getting to 20% medical/dental/mental health appointments, 19% shopping for essentials, 17% work, and 10% community gatherings.

Transportation is one of the biggest barriers for many farmworkers, especially those who migrate each summer to pick berry crops in Skagit and Whatcom counties. Many migrant farmworkers arrive at temporary housing, provided by the farm owner, in a single vehicle with friends and/or family members, leaving most of those who traveled in that vehicle during that season without transportation.

In addition, other migrant workers arrive at temporary housing, on a bus; also provided by the employer. Sometimes this transportation service is offered only once a week to migrant workers to get to a local store where they can cash the check received as a weekly payment or to a department store where they can do most of their grocery shopping; normally this place is Wal-Mart.

Most women in indigenous communities do not usually drive, that is a male role. Usually, the husbands or older children do it. However, the new generations have changed that, the young women of these communities are driving more and more every day, and adopting more independence than their mothers and grandmothers did during their age.

The farmworker community is not a user of local public transportation. The reasons are multiple; routes are sporadic and bus stops are far from rural areas. Many people would have to walk more than a mile to get to the bus stop; not to mention that many times they have to go with children. Public service within the transportation system, both at the station and within the buses, is geared toward the English-speaking community. We also have to mention that many times police patrols frequent the areas surrounding the station, a situation that intimidates the agricultural community to dare to use this service and discourages the idea of learning to navigate the local public transportation system.

- *Most farmworkers do not have access to a car or cannot drive (Bircher, 2009) (Pillings, 2015). In Pillings' study, transportation was one of the main barriers to prenatal care. 13 of 15 interviewees said they did not have a car. They had to ask their husband or sister, while others relied on public transportation to get to appointments.*
- *Mexican farmworkers are more likely than black or white women to delay reproductive and prenatal care due to lack of transportation (Vázquez, 2006).*
- *In another case, a Mixteco woman missed her appointment because she was late due to public transportation delays (Maxwell, et al, 2018).*

Housing

Forty-four percent of respondents live in farmworker housing, 17% rent a home, 10% share a rental home with others, and 8% pay a mortgage.

Housing is a fundamental human right, which should fulfill the premise of being a safe and comfortable place where we can take refuge from inclement weather, the dangers of the streets, and the place we share with our families; our loved ones.

It is natural for people to develop a sense of belonging with this space called home, not only because personal belongings are found there, but also family memories. For this reason, not having a place to call home ends up negatively affecting a person's physical, mental, and emotional health. The relationship between physical space and what that physical space represents has a very big implication for the stability of a person throughout their life. All people should have the right to decent housing.

This is one of the most critical determinants of health; knowing the conditions of the places where the majority of agricultural workers live, is worrying because a large part of them are forced to live in places that do not meet the minimum safety and health conditions and are far from being spaces of family, "a home".

Many of the farm dwellings are in very poor condition as a result of poor maintenance:



<https://www.nbcnews.com/special/h2a-visa-program-for-farmworkers-surging-under-trump-and-labor-violations/>

<https://www.nbcnews.com/special/h2a-visa-program-for-farmworkers-surging-under-trump-and-labor-violations/>



Figure 12. Housing problems mentioned by survey respondents

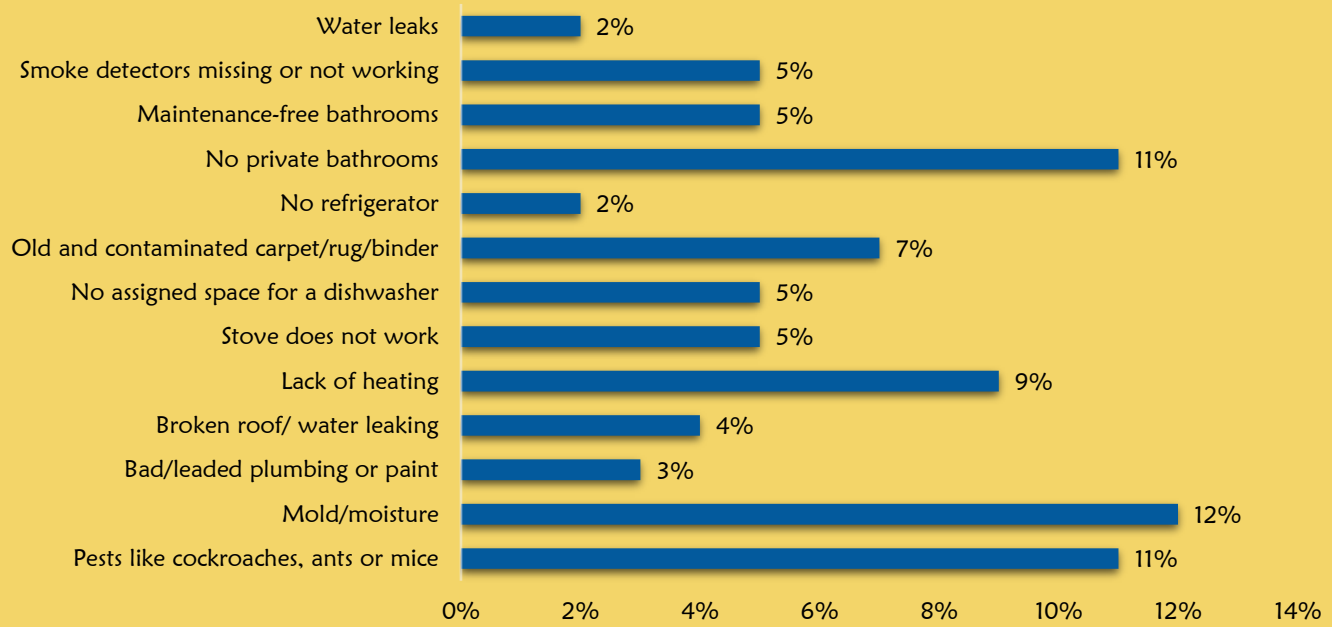
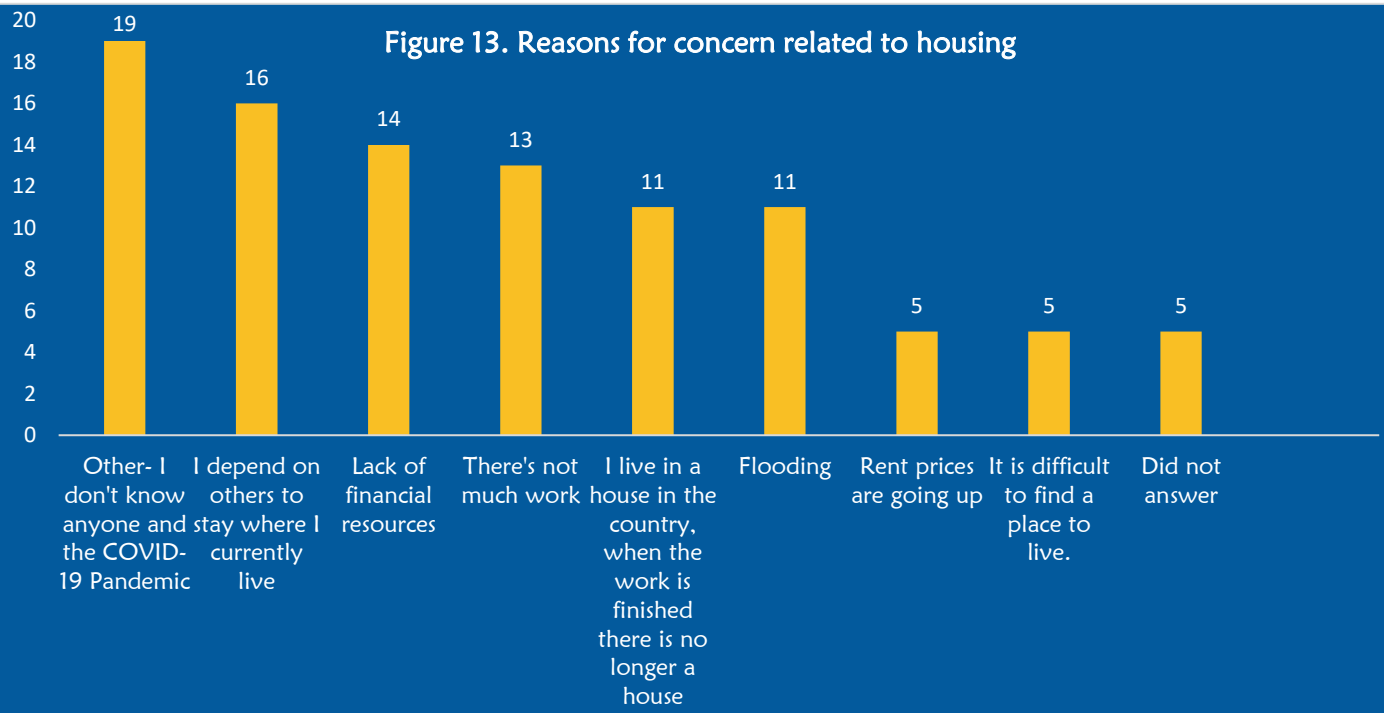


Figure 13. Reasons for concern related to housing



Twenty-eight percent of those surveyed responded that they were worried about losing their home.

The high mobility of migrant workers forces them to share their homes with other people who do not belong to their family nucleus. Living in overcrowded spaces increases the risk of creating family tensions, limiting privacy, and leading to depression, anxiety, and stress to the point of reaching domestic violence, triggering many other mental health problems that affect the children. In addition, the overcrowded condition increases the risk of exposure to contagious infectious diseases, sexual abuse, violence, and harassment.

Housing conditions can affect a person's physical and mental health and determine the quality of life for a family, a community, and a society.

Local farmworkers who live year-round in the area often find it necessary to take out loans to pay their rent. They usually do not fall behind; they would rather go into debt than fall behind on their payments because they know how hard it is to obtain a place to live. Access to housing is very poor in Skagit and Whatcom counties when it comes to affordable housing, the options are very few.

During the last two years, some organizations have been administering emergency rental assistance programs (ERAP) and Treasury Rent Assistance Program (TRAP). These organizations have used community programs to reach the farmworker community, thus ensuring open access for all. The experiences of reaching out to the community by offering this resource tell us a lot about how important it is for this community not to put their family's roof at risk. Of course, no one wants to put the place where their family lives at risk, however, when it was explained that one of the requirements to be able to access this resource was to be late with the rent payment, the vast majority of them preferred not to apply, since being late with the payment could mean losing their home.

In addition to the fact that housing options are very few, there are other factors such as a deposit, sometimes up to 3 months of rent, background checks that require identification and some tenants require social security, which makes it even more difficult for this community to obtain a stable place to live.

Many families decide to share their homes to reduce expenses and thus be able to cover other basic needs such as food and gasoline, among others. However, sometimes, this situation causes one of the families living under the same roof to be at a disadvantage compared to the other. The family who is not the direct tenant has to accept the conditions that the family that is renting requires. To comprehend the disadvantaged situations a little better; the tenant pays \$900 a month for a two-bedroom house in fair condition, four people live there, two adults and two children. The family that comes to share this house is also made up of four people, two adults, and two children; the space assigned by the tenant for this family is the living room and they will have to pay \$500 per month.

Other cases may be related to spaces other than houses or apartments where some families find it necessary to live and pay rent to have a roof over their heads. These spaces do not have the necessary conditions (water, heating, kitchen, bathroom, etc.) to be inhabited, such as a garage or a barn.

Exposure to mold, mildew, and other allergens due to moisture from lack of ventilation and structural maintenance; the presence of cockroaches, mice, and other types of pests due to the accumulation of garbage, sewage networks in poor condition, lack of insulation, cracks in the walls, and contact with pesticides and fertilizers; are some of the reasons why many agricultural workers report continuous infections, allergies, and respiratory conditions that are recurrent in both adults and children (Quandt et al., 2015). Although they receive medical treatment for these conditions, improvement is often not seen since they continue to be exposed to the triggers that produce these diseases.

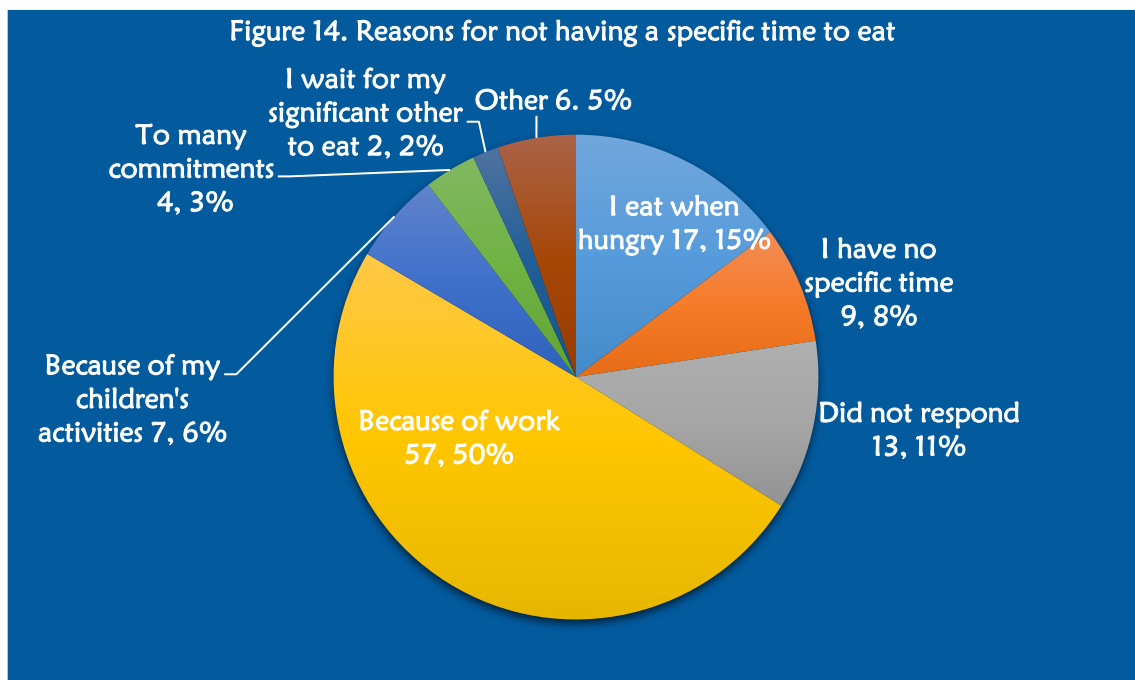
Farmworkers are continually exposed to toxins that slowly poison their respiratory system. They also expose those toxins to their families after their work in the fields. Between the years 1999 and 2003, the state of Washington used more than 400,000 pounds of three different organophosphate insecticides (Griffith et al., 2018). To put it into perspective that works out to 200 tons which is almost the weight of the Statue of Liberty. There is evidence to suggest that insecticides and pesticides contain organophosphates that are harmful to farmworker households and their communities, mainly because these organophosphates disrupt the neurological development of their children (Griffith et al., 2018). Without adequate

health coverage and care, we are putting our farmworkers at risk for multiple illnesses, injuries, and infections.

“Exposure to mold and mold spores causes respiratory health problems, particularly in sensitive individuals, including upper respiratory problems, cough, wheezing, asthma, and allergy symptoms. In other studies, humidity in homes has been linked to allergic reactions including hay fever and asthma, as well as recurring headaches, fever, nausea, vomiting, and sore throat. Unsanitary conditions, wall openings, poorly sealed windows and doors, or lack of window screens in homes can provide favorable conditions and pathways of entry for pests that can lead to the spread of infectious diseases and respiratory viruses. Allergic sensitization via cockroach and mouse allergens can trigger mechanisms for asthma, airway hyper responsiveness (AHR), and wheezing. Other potential indoor respiratory health hazards include pesticides and household tobacco, which can contribute to chronic phlegm, dry cough, increased wheezing, bronchitis, headache, and tiredness.” (Kearney et al., 2018).

Eating Habits

Survey respondents were asked, do you have a specific time to eat every day? In addition, 53% answered yes, 46% no, and 0.3% did not answer the question.



The number one reason farmworkers do not have a set mealtime is work. Often, especially those who work in the fields prefer to finish their assigned tasks before taking a break to eat and/or hydrate.

Although there are currently laws that protect farm workers so that they can have established meal and rest times, these are not always fully complied with (WA L&I, 2022).

For many farmworkers, it is more convenient in economic terms to avoid these time breaks because that means less money in their pocket. Especially when they work by contract or "by pieces", here the number of pounds of fruit that is picked "piscan" is very relevant. Harvest time is limited, and it is the only opportunity during the year that migrant farmworkers have to increase their economic income, which will help them sustain themselves through those months when the amount of work decreases considerably.

Clearly, it is the expert pickers who come each year to harvest the berries: strawberry, raspberry, blackberry, blueberry, and some vegetables such as cauliflower, among others. The opportunity to make more money is mainly during the harvest time of the blue berry in July and August, sometimes until mid-September when there is enough sun. Only those farmers who have greenhouses manage to harvest the blueberry when the temperature drops.

There are other reasons farmworkers do not take their meal times regularly or take breaks more often. Sometimes they feel pressured by their superiors to finish the furrows. In addition, that implies, on many occasions, walking a long distance to the places assigned for rest, or where their cars are parked, where they normally have their food and drinks. Some even report that sometimes they resist the urge to use the bathroom.

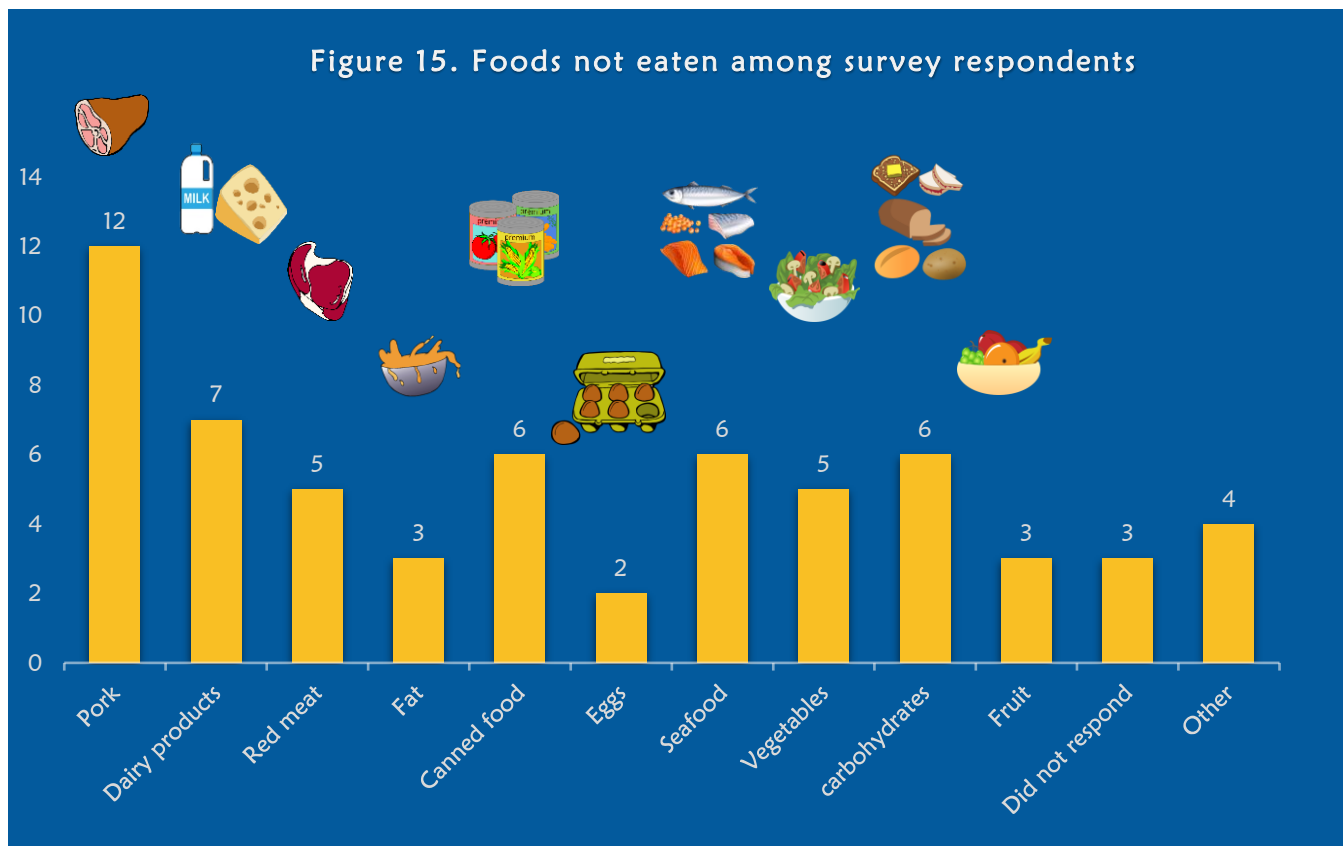
The long hours of work often lead the farmworker to choose foods that give a feeling of fullness, but with low nutritional content, the quality of the food consumed becomes another cause of health problems.

Nutrition, hydration, and active breaks during working hours are determining factors in the health of human beings. It is necessary to educate the agricultural population about the

importance of taking breaks and eating and hydrating healthily, and the implications that not doing so brings to health.

Appropriating the food that is provided

Investing time in the development of workshops, offering basic and practical guides on how to prepare healthy nutritious foods with culturally appropriate ingredients and gradually introducing new substitute ingredients while taking into account that there are certain foods that the local agricultural community does not consume would greatly help to make a progressive change that would have a positive impact on health in general. Over the years we have learned that most members of this community do not consume any type of canned or processed foods (canned beans, tuna, tomato, meats, etc.), or boxed cereals. Indigenous farmworker communities, in particular, are used to only eating food with fresh ingredients. Some staples used daily include tomato, onion, cilantro, fresh or dried chiles, zucchini, bell peppers, radishes, avocados, rice, black and/or pinto beans, oatmeal, cornmeal, wheat flour, plantains, apples, oranges, vegetable oil, coffee, and tea.



Traditional foods of Mexico and Guatemala



Marcos Castillo / Shutterstock

The 7 Moles from Oaxaca



Playa del Carmen / Shutterstock

Oaxacan tamales



Tlayudas



<https://guatemalanfoods.com/pepian/>

Pepian



antiguadailyphoto.co

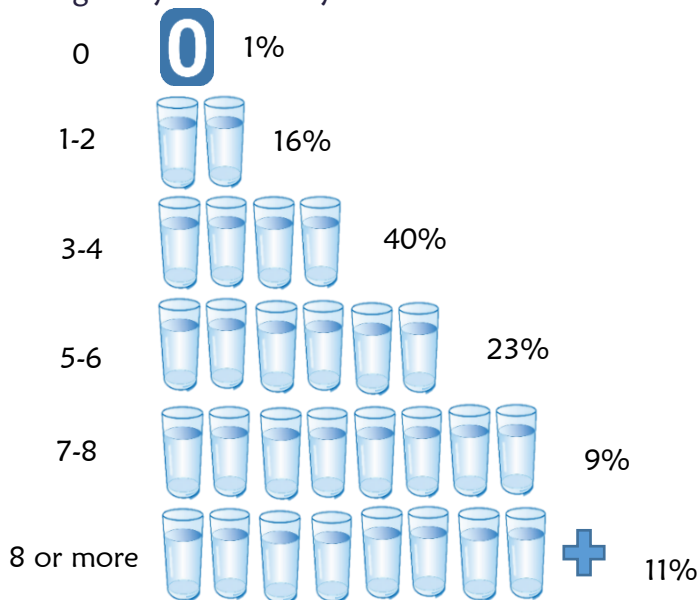
Chuchitos with chipilín



Isabella Estrada/ Cookpad

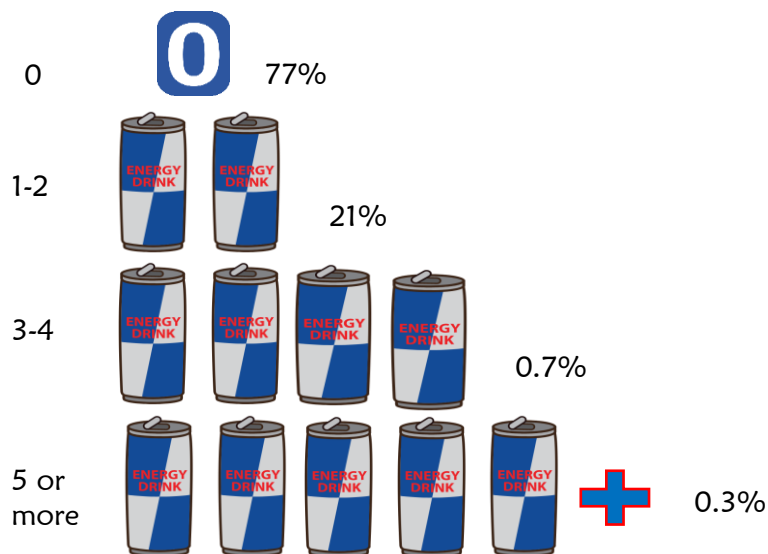
Guatemalan rellenitos with sweet beans

Figure 16. How many glasses of water do you regularly drink a day?



80% of those surveyed drink less than six glasses of water a day.

Figure 17. How many cans of energy drinks do you drink a day on a regular basis?

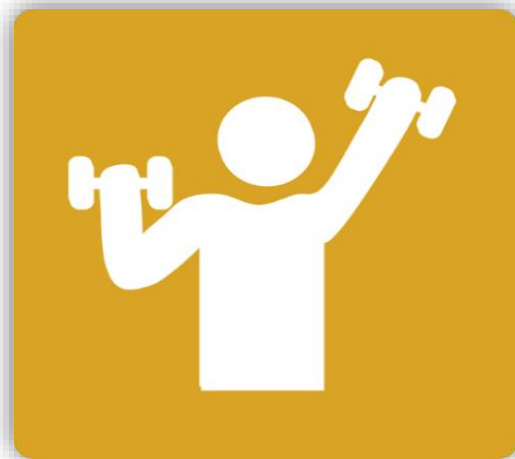


58% of those who answered that they drink 1-2 energy drinks a day regularly are men, 42% are women.

High humidity and extreme environmental temperatures, along with heavy physical labor and low water consumption, put people at risk for heat-related illnesses such as dehydration, serious and commonly unreported hazards in the agricultural industry. *“In 2008, the Washington State Department of Labor and Industries agriculture heat rule (WAC 296-307-097), which is intended to protect employees from outdoor heat exposure, went into effect. 11 The requirements apply to outdoor work environments from May 1 through September 30, when employees are exposed to outdoor heat at or above specific temperature thresholds that vary according to the type of clothing or personal protective equipment employees are required to wear. When clothing-specific temperature thresholds are exceeded, employers must include an outdoor heat exposure safety program in their written accident prevention program and encourage employees to frequently consume potable water or other acceptable beverages to ensure hydration. Specifically, employers must ensure that sufficient quantities of potable water are accessible to employees at all times and that all employees have the opportunity to drink at least 1 quart of drinking water per hour. In addition, supervisors and employees must receive training related to working in hot conditions before outdoor work that exceeds temperature thresholds.”* (Bethel, Spector, & Krenz, 2017).



A 2% of those surveyed reported sleeping less than 4 hours and 21% between 4-6 hours.



A 54% of those surveyed reported not doing moderate exercise (such as brisk walking, running, dancing, swimming, cycling, or other similar activities) during the week.

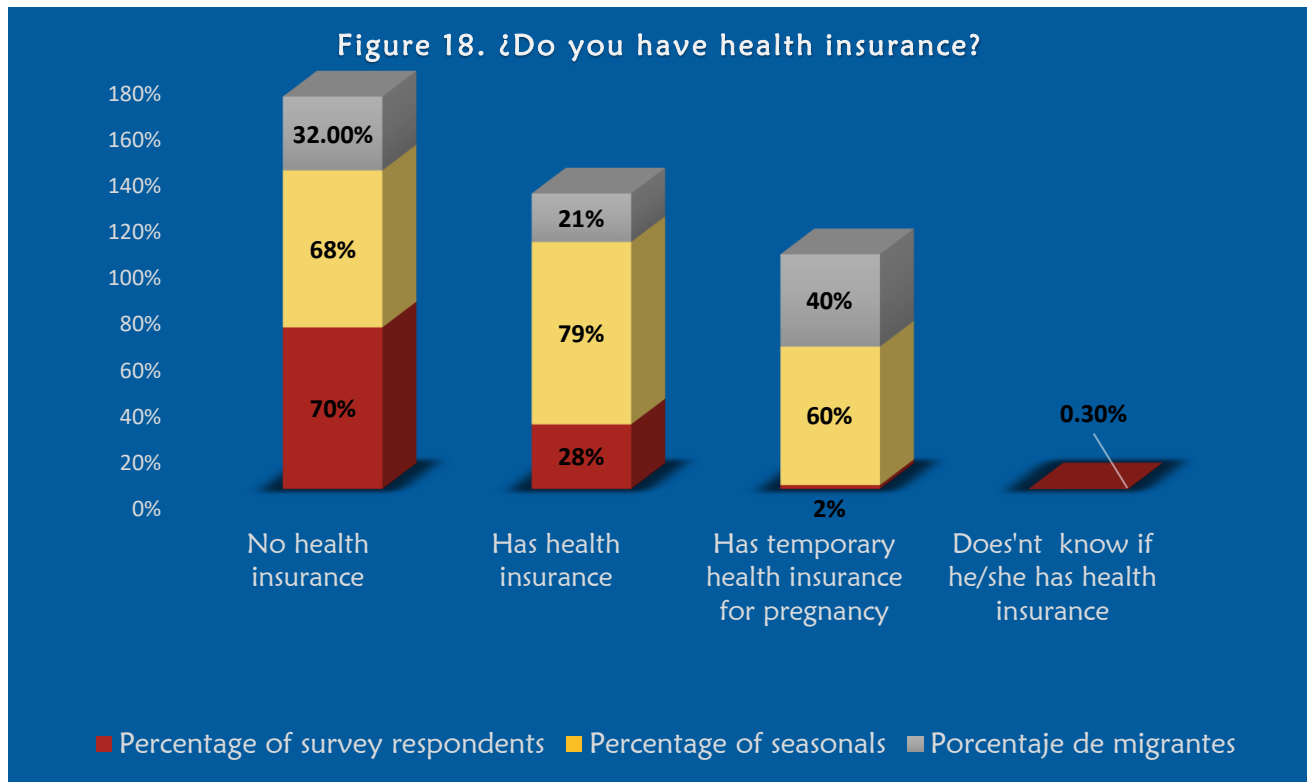
Work in the fields is physically demanding, so it is necessary to obtain 8 hours of uninterrupted sleep to restore energy. It is common to hear from the agricultural community that they do not get the recommended 8 hours of sleep, because their days are full of work and chores at home and with the family. Other comments also include financial and/or family concerns. Adding to all of the above, in many of these families, everyone sleeps in the same room, making it difficult to get a deep, restful sleep.

Agricultural workers are at risk of occupational injuries and developing chronic diseases (Brumitt et al., 2013). Exercise can improve health and help reduce the risk of occupational injuries and/or reduce the risk of developing a chronic health condition. The Centers for Disease Control and Prevention (CDC) have established basic fitness recommendations for adults. Adults (ages 18 and older) should, at a minimum, do strength-training exercises 2 days a week and 150 minutes of “moderate-intensity aerobic activity” or 75 minutes of “vigorous-intensity aerobic activity” during the week or a combination of moderate and vigorous aerobic activity (Brumitt et al., 2013).

Although farmworkers burn many calories walking through the furrows in high temperatures, this activity is not done with proper clothing that allows them to perspire, on a flat surface, and with regular hydration. Clearly, there is no encouragement to do healthy physical activity because the body is exhausted and injured. Education about the importance of regular exercise and stretching among farmworkers cannot only help reduce injuries but also improve health.



Health and Lifestyle



Seventy percent, of those surveyed, reported not having health insurance and 2% had temporary health insurance due to pregnancy.

Agricultural workers are part of the population with low access to primary care health services. Low access is due to the cost of these services. Many farmworkers either do not have health insurance because they do not have the legal status to obtain state insurance or are unaware of programs that can help them use health services.

The cost of health services discourages many from seeking routine preventive health appointments. This can often result in the community member seeking health services when she/he can no longer handle the discomfort or pain, which can be more expensive.

Although not having health insurance is a barrier for the agricultural community, it is important to make it known that there are means so that the cost of health services is not an impediment. There are sliding scale discounts at federally qualified health centers, state

health insurance programs, health insurance offered by some employers, and free mobile medical and dental clinics.

Mitigating these barriers to access, in 2009, the MSAW Promotores de Salud Program was established at the Sea Mar Community Health Centers as a program focused on reaching the local agricultural community. The program develops, organizes, and delivers mobile clinics during the summer for migrant farmworkers at temporary farmworker housing located on the largest farms in Skagit and Whatcom counties. The mobile medical and dental services offered during these clinics have been an important gateway to primary care health services for the migrant farmworker community that comes year after year to pick the berries in the fields of Skagit and Whatcom counties.

For the past 8 years (2014-2021) during the berry harvest season (12 weeks) which can start in late May and end in early September depending on the weather, the MSAW Program has served 783 farmworkers with direct medical services, 704 with dental services, and 2,357 health screenings (blood pressure, blood sugar, HIV, Gonorrhea, Syphilis, and/or Tuberculosis questionnaire). All of these services have been free to all the farmworkers served during these mobile clinics.

Through these events, it is possible to mitigate the barriers of lack of health insurance, money, transportation, language, and time; making sure that the opportunity to access these services is a reality.

The barriers to accessing health services are the same for workers who migrate during the summer and for those workers who live in the area all year.

The language barrier is one of the most prominent that prevents access to services in general. The simple fact of making an appointment by phone becomes a challenge, the individual cannot communicate since there is usually a waiting message in English where it is mentioned that a command can be dialed to receive attention in Spanish, and however, the initial option is in English. Even more difficult when the individual does not speak Spanish, since no local agency offers this service in indigenous languages (Mixteco, Triqui, Awakateco, Chalchiteco, and Mam, among others). When the meetings are face-to-face, there is not always an option to have interpretation in these languages. Members of the

client's family sometimes end up being those who interpret (sometimes children); a situation that often puts both the one who uses the service and the one who is interpreting in an uncomfortable position due to the kind of information being exchanged, especially in medical settings.

Another very common situation is the possibility of having an interpreter who vaguely understands the language; especially tele-interpretation. To be more specific we refer to the Mixteco language. This language has more than 50 variations; the variation is determined by the place of origin of the person's "town". Knowing this information helps to know the variation of the language needed to interpret with equity. We have learned from the community that some variations are similar and that a conversation could be followed in its general context, however, other variations are very different from each other; this is the reason why as agencies we must make this communication problem aware and work on opening access by offering adequate interpretation services. It should be noted that there are 3 variations of Mixteco that are predominant in the area, 2 of these 3 variations are Mixteco Bajo and 1 Mixteco Alto. Covering these 3 variations would significantly improve the interpreting service for the local Mixteco community.

Below, we present the towns that speak the same variation or that their similarity is great enough to be able to communicate with each other.

Language	Town	Municipality	State
Mixteco Bajo First Variation	Santiago Asunción	Silacayoápam	Oaxaca
	Santa María Asunción	Ixpantepec Nieves	Oaxaca
	Santa María Natividad	Ixpantepec Nieves	Oaxaca
	San Martín Sabinillo	San Miguel Tlacotepec	Oaxaca
	San Juan Huaxtepec	Silacayoápam	Oaxaca
Mixteco Bajo Second Variation	Santa Cruz Yucucani	Tlacoachistlahuaca	Guerrero
	San Jorge Río Frijol	Putla Villa de Guerrero	Oaxaca
	San Juan Piñas	Santiago Juchitahuaca	Oaxaca
	Coicoyan de Las Flores	Coicoyan de Las Flores	Oaxaca
	Tierra Colorada	Santa Catarina Ixtepeji	Oaxaca
	Tilapa	Santiago Juchitahuaca	Oaxaca
	San José Yosocañú	Constancia del Rosario	Oaxaca
Mixteco Alto	Santo Domingo Yosoñama	San Juan Numí	
	San Jose	San Juan Numí	Oaxaca
	San Juan Numí	San Juan Numí	Oaxaca
	San Pedro Numí	San Juan Numí	Oaxaca
	San Pedro Yosoñama	San Juan Numí	Oaxaca
	Santa Rosa	San Juan Numí	Oaxaca
	San Isidro Yosoñama	San Juan Numí	Oaxaca
	San Isidro Numí	San Juan Numí	Oaxaca

	Guadalupe Mirasol Ñumí	San Juan Ñumí	Oaxaca
	Santiago Nundiche	Santiago Nundiche	Oaxaca

The MSAW Promotores Program has heard from several Mixteco-speaking families who have received written information in Mixteco from government institutions and local hospitals that they cannot understand the written information. As mentioned in the “Education” section, although there are some variations of Mixteco that may be similar to each other, there is no universal spoken and written variation of Mixteco. In addition, many members of indigenous communities, especially women, do not read or write the variation of Mixteco they speak.

The hours of operation of many community organizations are also a barrier for farmworkers. Long working hours prevent them from using some services at times that are convenient for them. It should be noted that some local medical clinics have extended hours after 5 pm and on Saturdays, this opens up access to primary care medical services for this population.

Another barrier that members of the agricultural community mention that discourages them from seeking health services are the long wait time on the day of the appointment and rushed meetings with providers.

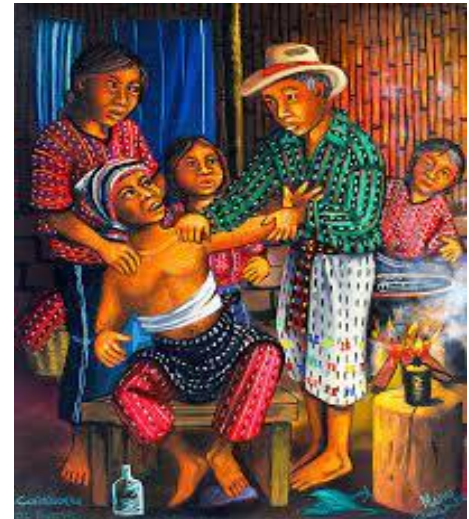
It is important to note that farmworkers seek out Western medicine only after available home remedies and other resources that they used to use in their home countries have failed. They often end up in the emergency room because the problem has increased over time.

Culturally, the concept of preventive health does not exist in agricultural communities, much emphasized in indigenous communities that represent 60% of local farm workers.

Indigenous beliefs about health



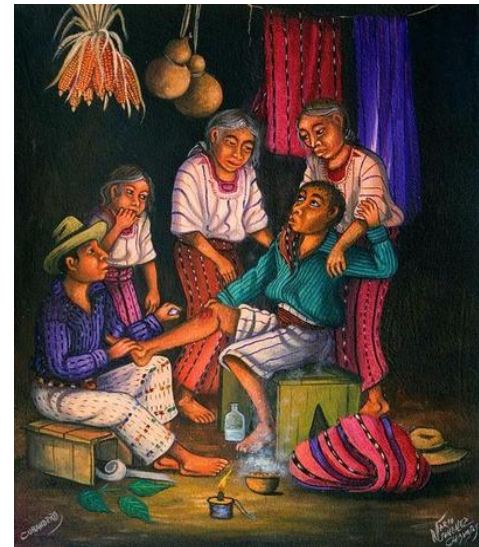
Mario Gonzalez Chavajay



Mario Gonzalez Chavajay



Mario Gonzalez Chavajay



Mario Gonzalez Chavajay

Indigenous beliefs around health, wellness, and disease are rooted in ancient Mayan and Aztec belief traditions that nature, society, the spirit world, and the cosmos are all interconnected. Heat illnesses are thought to cause excess heat in the body and cold illnesses cause excessive temperature loss. The key to health is to balance hot and cold. For example, avoiding cold foods if you are too cold and using sweat baths. The hot elements are associated with the sun, the sky, the masculine, order, light, and life. The cold elements are associated with the moon, the earth, the feminine, disorder, darkness, and death. Both are necessary for life. Like a plant, it needs the heat and light of the sun and the cold forces of the earth (soil) and death (decays). Many illnesses are also attributed to supernatural causes

such as evil spirits, the evil eye, and violations of taboos. (Nichols Mines, Runsten, 2010, Newsline, 2011).

Indigenous communities may seek medical treatment to help alleviate certain symptoms, but they also seek the help of a curandero or shaman and healing ceremonies to restore the balance between man, nature, and the supernatural (Mines Nichols, Runsten, 2010). A curandero uses herbs and plants, massage and physical therapy, bone manipulation, and/or counseling in combination with religious or other rituals to treat illness and restore balance. They use healing ceremonies to balance and cleanse the body's energy and to diagnose physical and spiritual causes. They carry out a “cleanse” or spiritual cleanse to diagnose and cure some popular illnesses, using an egg or a bouquet of herbs and prayers. Common diagnoses are susto (soul loss, which is when a person's inner soul leaves the body due to shock), espanto (a scare), mal de ojo mainly affecting children (a person intentionally inflicts harm or no), sadness (sadness or depression) and envy (envy) (Mines Nichols, Runsten, 2010).

Over-the-counter medications are often used in conjunction with religious ceremonies. This folk medicine is often practiced in many rural farming communities around the world, where access to hospitals and health centers is non-existent or very limited. They may alternate between traditional and conventional medicine, depending on the severity of the illness or the circumstances.

According to Migrant Health Newsline, people will not stop seeing their healers. Even in areas bordering Mexico, curanderos are popular because sometimes-sick people may prefer to seek out someone they feel understands them. The patient is more open to telling to a Latino curandero things that he/she would never share with a doctor or nurse.

Those who have lived for years in the U.S., and specifically in the Skagit and Whatcom County, have learned to look to both Western medicine and their traditional healing practices. Other migrants or newcomers still rely heavily on their preferred traditions of seeking out healers.

Overcoming resistance to using health clinics in the U.S. is about more than meeting your language needs. They may not understand what is happening and may feel confused or

angry about their treatment. (Migrant Health Newslines Oct/Nov/Dec 2011). Local organizations and agencies serving members of this community have a responsibility to provide the support they need to navigate the system. This involves helping them fill out applications/forms, providing interpretation services in their native language, and giving them the option to do any process to acquire services in person and by phone. Some members of the community require extra help; in these cases, one-on-one accompaniment is critical for these individuals to be able to use the services.



Prenatal care in indigenous communities (Mixteco, Triqui, Awakateco) living in Skagit and Whatcom counties

“Migrant and seasonal agricultural workers including indigenous women who are not of Hispanic descent face many barriers to access prenatal care. We conducted a survey in Spanish and three indigenous languages—Mixteco, Triqui, and Awakateco—to explore knowledge, attitudes, and behaviors regarding prenatal care among 82 female agricultural workers residing in the state of Washington. Our findings highlight the importance of collecting disaggregated data from different indigenous communities and of providing indigenous language support. Our study provides new information for developing messages to promote prenatal care that take into account the knowledge and beliefs that are prevalent in these communities.”

Members of the MSAW Program conducted this study published on May 25, 2022

<https://www.tandfonline.com/eprint/HXAXGVVXEYTZMNCMFS4M/full?target=10.1080/23293691.2022.2061319>



- 10% of respondents reported that the last time they saw a doctor was 4 or more years ago, and 5% have never seen a doctor
- 67% of those who have seen a doctor 4 years ago are seasonal, and 33% are migrants farmworkers
- 47% of those who have never seen a doctor are seasonal, and 53% are migrant farmworkers

- 15% of respondents reported that the last time they saw a dentist was 4 or more years ago, and 18% have never seen a dentist
- 67% of those who have seen a dentist 4 years ago are seasonal, and 33% are migrants farmworkers
- 58% of those who have never seen a dentist are seasonal, and 42% are migrant farmworkers

Figure 19. Diseases commonly mentioned among survey respondents

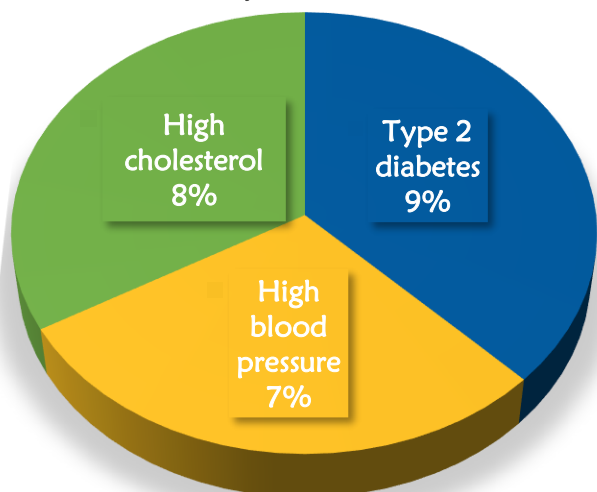
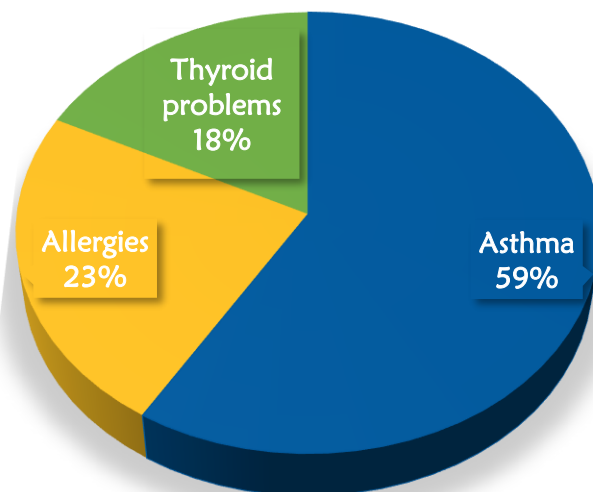


Figure 20. Diseases commonly mentioned among the children of the respondents



Substance Use

Seven percent of those surveyed responded that in the last year they have used prescription drugs in a way that they should not be used.

We have heard from some members of the community who have received medical prescriptions for pain pills, which in addition to relieving pain help them experience a sense of happiness, forget about problems, and better resist physical exertion; making work days less difficult. For this reason, they want to continue taking them permanently.

- *“74% of farmworkers are or have been affected by opioid misuse.*
- *26% of farmworkers have abused, been addicted to, or taken an opioid without a prescription.*
- *77% of farmworkers believe opioid pain relievers would be easy to access without a prescription.” (Michigan State University, 2021)*

Sixteen percent of those surveyed responded that they usually take pills to have more energy to work, feel less fatigued, and/or have muscle pain.

Heavy lifting, prolonged kneeling, constant bending and twisting, and repetitive movements all lead to musculoskeletal and traumatic injuries (NCFH, 2018). Between 2008 and 2010, 50% of all contract farmworker injuries were classified as strains or sprains (NIOSH, 2021). It is understandable why farmworkers use pain pills more and more frequently.

It is essential and the responsibility of employers to ensure that they implement an occupational health protocol that involves morning stretching and warm-up. Also, training in proper techniques to lift heavy objects correctly, such as the posture to bend over, the position of the knees, the compression of muscles, and the position of the back, among many others. It would be ideal if mandatory regulations were established to avoid or minimize the risks derived from agricultural activities, providing employees with the necessary equipment to preserve health and well-being.

Respondents were asked: “How many times in the last 12 months have you had 4 or more alcoholic drinks per day?” Thirty people reported doing it monthly, 15 weekly, two daily, or almost daily. According to this question, 15.4% of the total sample of those surveyed are alcoholics.

Cultural traditions and social attitudes towards alcohol, as well as the norms and belief systems of an ethnic group, are reflected in the way individuals drink. These determine what is considered acceptable behavior, both in the family context, as well as in the community and in social interaction. Culturally, the Latino community has weekend social habits where most of the time alcohol is consumed.

Although some minorities allow women over the age of 15 to consume alcohol without being singled out, there is generally disapproval of alcohol consumption for women; excessive consumption and drunkenness are seen as activities of men. These are community normalized depending on gender. It is not bad for a man to get drunk, but it is very frowned upon for a woman to do so. So we would say that there is a cultural background in the Latino-indigenous and non-indigenous communities related to alcohol consumption. However, in some Latino-Indigenous communities, married women with their husband's permission may drink alcohol outside of the social context. We also have to mention that after living in the United States for several years many single women of adult age (usually in their thirties) consume alcohol without being singled out.

In the SDOH survey, six people reported having used marijuana in the past year, and seven people reported having used any of these drugs: heroin, cocaine, amphetamines, hallucinogens, or others.

The consumption of substances other than alcohol is rising in the new generations of agricultural workers.

It is important to mention that many agricultural workers from indigenous communities have never heard any educational topic about the negative consequences that drug and/or alcohol use and addiction can have on health and the family. Many agricultural workers from indigenous communities are from small towns where it is not common to hear

health information about these subjects. It is for this reason that health education on these should be offered to these communities.

Safety

In the SDOH survey, a category was included about safety in family relationships, at home, and at work. Some of the questions included addressing safety in family relationships were: **In the last year, has someone in your family physically hurt, insulted, and/or threatened you? 29.5% of the participants answered this question affirmatively, 41% men and 59% women. In the last year, have you been afraid of your partner or ex-partner? Five% of the participants answered this question affirmatively, 43% men and 57% women.**

Intra-family security is made up of a series of rules and behaviors aimed at minimizing, controlling, and neutralizing situations of violence that all family members should fulfill. However, these rules and behaviors are not taught and therefore are not practiced, nor do they give the importance that this requires. It is, for this reason that from the ignorance of what is good behavior and based on example, which is the best way to teach, is that the agricultural community is frequently involved in situations of violence and interfamily insecurity. We mention "the example" because violence is a present element, almost normalized, and that all family members end up accepting, not because they think it is okay, but because the fear generated through these behaviors invalidates the defense action making this situation something that has to be endured.

As agencies, we must develop mechanisms and initiatives to share knowledge, offer existing resources more widely and develop new aid strategies that meet the specific needs of this problem within farm working families. Education is the basic cornerstone to start this, starting with educating young people about the rules of respect and equality between men and women. Teaching how to set limits and exercise the right to express opinions and thoughts about of decisions of each person, such as the decision to say no to sexual relations with the partner, the number of children they want to have, the right to use family planning methods and the shared responsibility of the obligations within a family.

The creation of programs that address the issue of domestic violence and insecurity from an education and accompaniment perspective will make it less difficult to introduce this

issue within families. The Organizations, Institutions, and Agencies that provide services to this community should be able to reach the different members of the families from their services, with resources that help guide families towards conciliation, dialogue, respect for the elderly, and mutual respect between parents and children. All of us as a community can get involved from different fronts and specialties to help them create a less tense and more embracing environment.

The education of the new generations will make a significant change in the way they fulfill their roles within the family in the future. Understanding that violence is part of generational trauma, especially within indigenous communities, we are obliged to be part of helping to break this chain that for generations has brought so much pain and suffering to these communities.

Regarding home security, 7% of the participants mentioned feeling unsafe in their current home, the answers were too vague and broad to pinpoint the specific reasons. However, for years, we have heard from the community some reasons that make them insecure about where they live. They have mentioned that not having a bathroom inside each of the temporary homes is a reason for high concern, especially among the female population. We might think that it is not comfortable to have to leave the home to use the bathroom, especially at night. Normally the bathrooms are not close to the homes, so they have to walk a stretch, in the middle of the dark to use the bathroom quickly and return to the home running for fear of being disturbed. Other reasons mentioned are related to the lack of structural maintenance (change of carpets, floors, paint, roof, sealing of windows, among others). *For more reference, see the Housing section.*

We have also heard that they depend on others to live where they currently live. Many farmworkers reside in temporary housing provided by the employer, this means that if the job is terminated because either the worker was laid off or because the contract simply expired, the worker is left adrift.

Regarding job security, 9% of the participants reported feeling insecure in their current job. The reasons mentioned were; racism, not enough work, and fear of being fired.

Farmworkers experience discrimination both in their home countries and in the United States due to racism, language, cultural practices, their origin, and physical traits. Research indicates that those who belong to indigenous communities face greater challenges than those who are not indigenous. Regarding the lack of work, the high harvest season, which is during May - September, constitutes the time of year with the highest economic income for local farmworker families. Only a few manage to stay employed throughout the year. Women especially remain unemployed and care for children during the fall, winter, and part of the spring. It is mostly men who get a source of income during these seasons. Jobs changes often occur and can be related to construction, landscaping, and other types of work not related to the agricultural industry.

There is a hierarchy within the fields; non-indigenous workers are in the middle of the chain of command (Holmes, 2013). There is favoritism according to legal status, and race for the assignment of positions. Indigenous workers are in the lowest line of jobs, they are usually the crop pickers. It is known that there is constant uncertainty about job stability. Sometimes they are afraid to ask when their payment is not proportional to the amount collected when it is by contract, or to the number of hours worked. The fear of retaliation invalidates the act of claiming. They prefer not to say anything rather than be out of a job. However, there are also farms where the payment is exact and the environment is much less hostile when it comes to making claims (Holmes, 2013).

Female farmworkers are a vulnerable minority in the agricultural industry; some of them have to face additional challenges (Kim et al., 2016). Working in male-dominated environments and in some cases being undocumented exposes them to sexual harassment and even worse rape. The fact of having language barriers and living in isolation prevents them from making use of their rights. Many of them do not know that regardless of not having a legal status they can access resources for legal help, protection, and counseling. Misinformation about their rights, fear of the threat of being fired, possible deportation, the loss of their partner's job, and in some cases the loss of housing for their family means that reporting these cases is minimal. The vast majority are young women, many of them with a partner and children, a condition that puts them in an even more difficult situation if they report harassment or rape (Kim et al., 2016).

Mental Health

Discrimination, extreme poverty, language, and all the challenges associated with the conditions of agricultural work, such as exposure to the elements, dangerous work, inadequate housing, social isolation, and lack of transportation, among others, make the work of the farmworker full of insecure areas. The life of the agricultural worker is a life of many physical efforts, sacrifices, long hours of work, little rest, lack of entertainment, very basic food, lack of care, lack of preventive health, no right to vacations, economic restriction, among many others. Factors that lead them to suffer from depression and anxiety.

From a very early age, people begin to work in the fields without any preparation, simply perpetuating the work that has been done from generation to generation. In the hometowns of migrant communities, education in schools is very basic, and there are no preparatory schools. Many leave their families to come to work in the United States so they can send money to support their families. They are not pursuing anything other than a way to make a living, an option they do not have back home. Many of the rural populations in Mexico and Guatemala, places from which the vast majority of agricultural workers come from to the state of Washington, do not offer consistent and moderately well-paid work that offers the possibility of improving the quality of life of migrant farmworker families. That is the number one reason for farmworker migration to the United States. **There are no American dreams to chase here, just a livelihood, farmworkers come to work!**

One of the questions in the SDOH survey was formulated as follows: “Stress means a situation in which a person feels tense, restless, nervous, or anxious, or cannot sleep at night because of worry or too many things on their minds. Do you feel this kind of stress these days?” Survey participants replied:

- Some days, 33.4%- 40% are men and 60% are women
- Many days, 6.3%- 21% are men and 79% are women

Another question on the SDOH survey was “Do you spend time and talk often with your family, friends, or other people who are important to you?”

•6% said they do not share time with family or friends; they have no one to talk to. Being these 47% men and 53% women.

There is chronic stress that is not exclusive to the farmworker community. Each day brings challenges of a different nature for the vast majority. We are living through difficult times with a lot of uncertainty at the social, economic, and political levels, among many others. Thinking about the situation of the working class, who are those who go to work daily, pay rent, support a family, sometimes get into debt to cover expenses, and maintain this lifestyle permanently, depending on a weekly payment or fortnightly. This somehow allows for certain stability, although under a lot of pressure and persevering on a day-to-day basis. Now let us think of a group of people without a stable job, not by choice, and consequently without a stable place to live, added to the barrier of not having a legal status that clearly limits job opportunities and ignorance of the system and the language situation that forces them to live in total isolation. This group of people lives at the limit of their ability to withstand a life situation led by stress, stress out of all proportion.

The impact that this brings on the physical and mental health of an individual is devastating, this is the reason for multiple diseases that end up destroying hope, and motivation, and leaving a person without a purpose in life. In addition, depression, anxiety, panic attacks, and all emotional illnesses boil down to physical illnesses.

Mental illness in the farm working community comes from their life situation. Prolonged stress is capable of inducing a person into a dangerous state of mind to the point that it leads to decisions against his/her own life. We must raise awareness of the need for accompaniment, acceptance, love, and support, especially for those who live daily with everything against them. These needs exist and are of great relevance to any human being, as well as the basic needs of food, housing, clothing, and medical attention.

Over the years, the MSAW Promotores de Salud Program has seen up close the unmet need of the agricultural community to be heard, understood, and to have the support of someone they can trust. For indigenous communities, these needs are even more difficult to meet due to the multiple cultural barriers they face in having to live and work in a place so different from where they belong.

The MSAW program is made up of people who belong to the communities we serve, many of them from indigenous communities, thanks to them we have been able to develop a model of outreach to these communities where empathy and respect reign. Based on this principle we can serve these individuals by making sure they feel understood, heard, and accepted. It has been shown that the community response is immediate when there is decent treatment. Although preventive health is not part of their culture, they dare to embark on a new experience with health, leaving aside the taboo, disbelief, fear, and mistrust that occurs when facing something unknown. Furthermore, they break cultural norms that may be contradictory to some Western medical practices.

Groups reaching indigenous farmworker communities should consider implementing mental health training with different approaches such as self-care, self-esteem, trauma care, awareness, resilience, and boundaries. As this will bring significant added value to the community work they do. If the intention is to reach this community effectively, we should adjust our reach and put it within certain parameters that are specifically directed to this priority population.

The MSAW Promotores de Salud team has benefited from this training, not only as a point of support doing community work but also in their own lives. This has been an investment that we already see reflected in the community.

The COVID-19 Pandemic

Seventy-eight percent of those surveyed reported having received the COVID-19 vaccine and 22% answered that they had not.

Figure 21. What motivated you to get the vaccine?

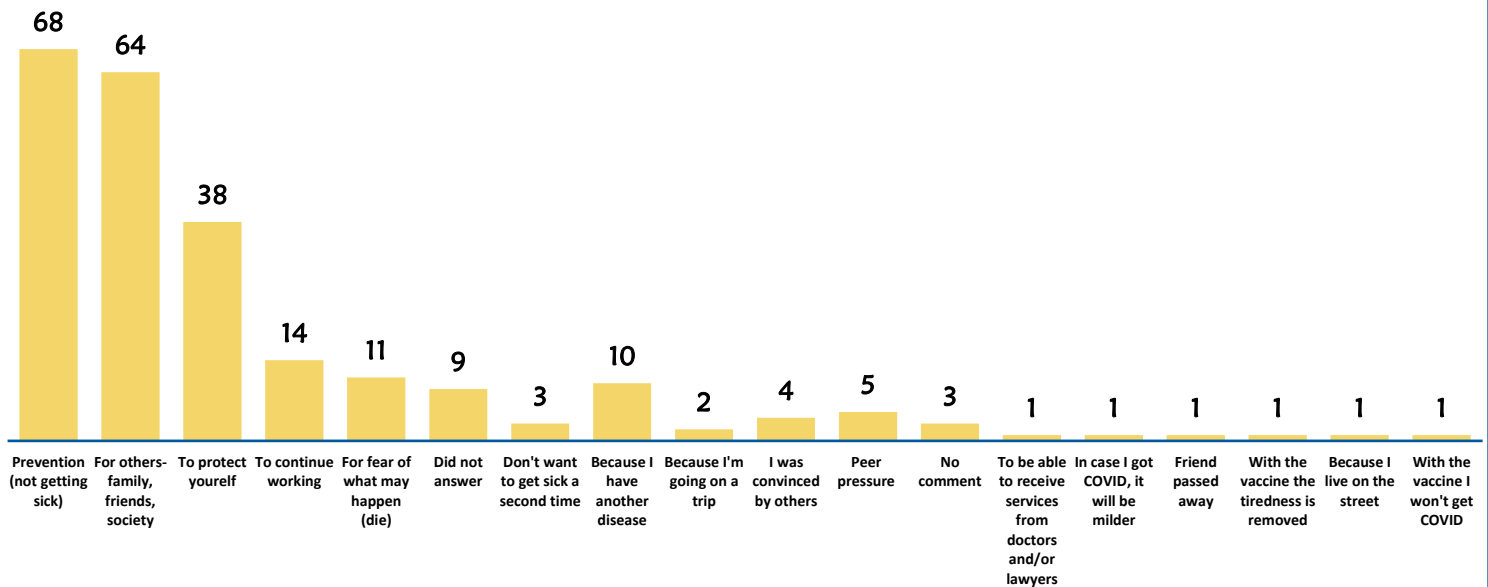


Figure 22. Reasons why they do not get vaccinated against COVID-19

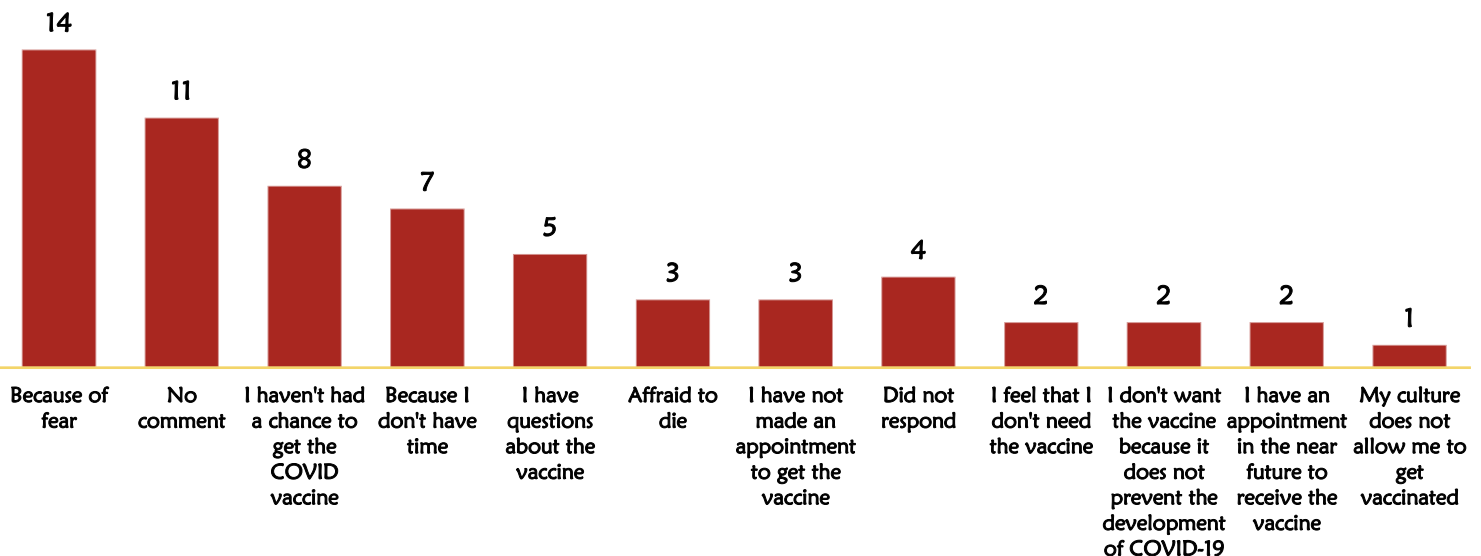


Figure 23. What have you heard about why other people are refusing the COVID-19 vaccine?

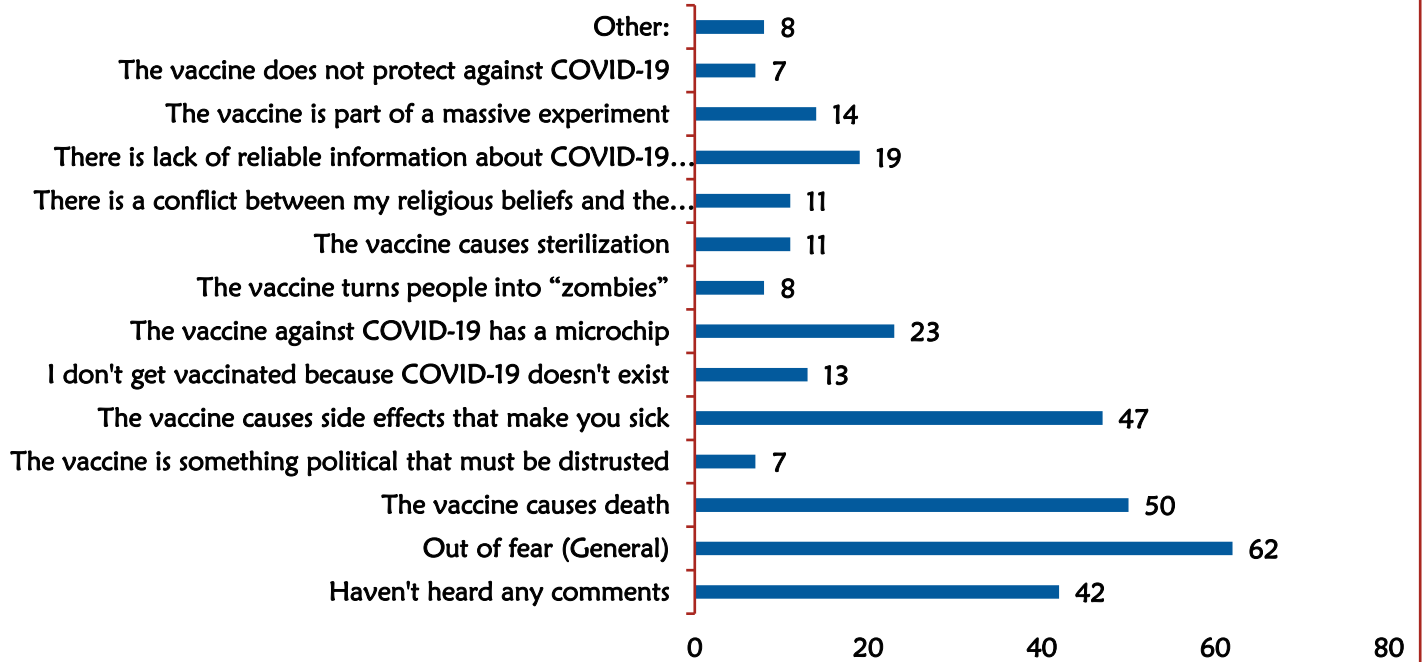
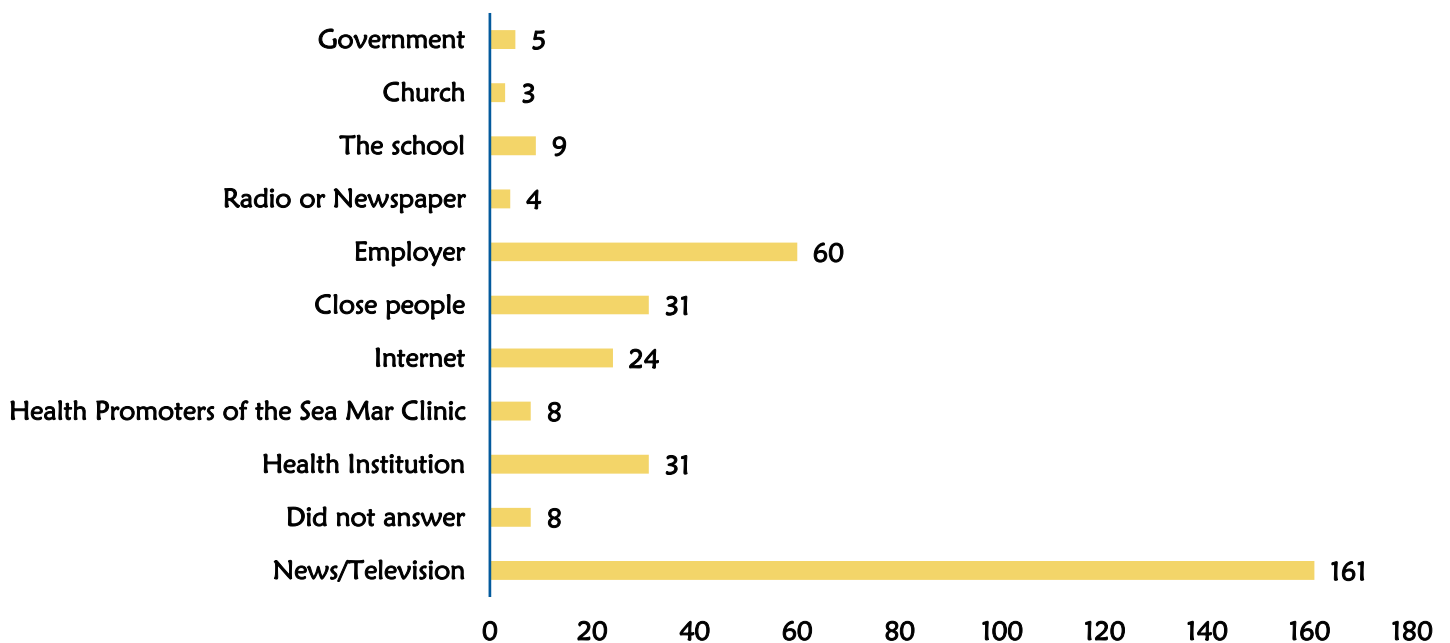
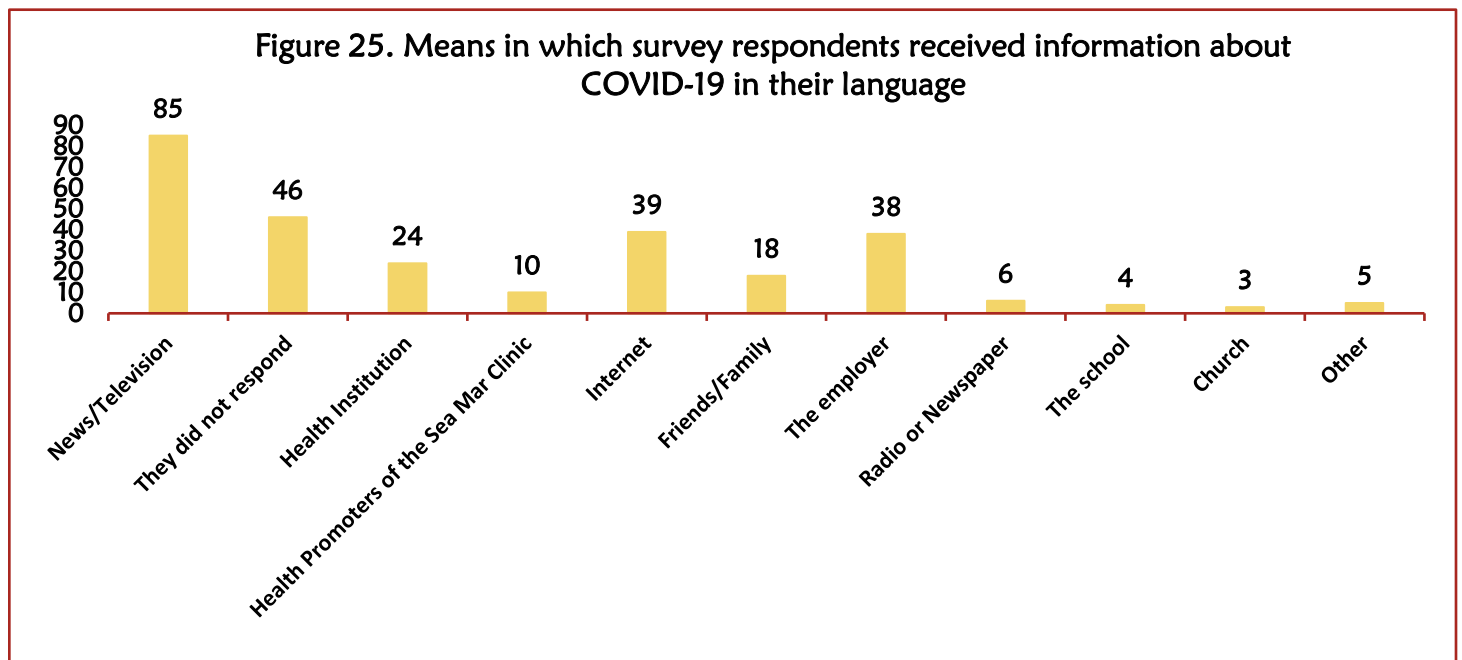


Figure 24. Who gave you information related to the Coronavirus for the first time (Information on symptoms, what to do if you have them, where to go, etc.)?





79% of those surveyed reported that they did receive information about the Coronavirus in their first language, 20% answered no, and 1% did not answer the question.

Due to the pandemic, most industries began to work remotely, however, from that moment on; many jobs were called "essential". Agricultural work was one of them, ironically, to the extent that finally publicly the work of the farmworkers (some of them who perform this work being undocumented) was valued by government institutions.

Essential workers were required at their work sites and their work was not affected in terms of attendance.

Government institutions established preventive health measures for the population, including farm workers. Unfortunately, the housing conditions of agricultural workers do not have the characteristics to be able to fully comply with preventive measures such as social distancing.

It is contradictory to think that farmworkers, as essential workers were even more vulnerable amid the pandemic than the rest of the population called "essential workers." Before, it was difficult for them to deal with so many barriers; now, they had to expose themselves without having personal protective equipment at their disposal. Often transporting

with many people in a single-vehicle and to this was added that they had to share very small spaces in their homes. The economic factor was also affected because the students had to have school at home. In a family with two working parents, only one could work, thus reducing their income by half.

Keeping the children home all day became a challenge for the families. Many factors were against family harmony, the simple fact of accessing the internet to be able to have classes was a nightmare. Many of the farm working families did not have a computer or Internet access in their homes. Many of the parents had the experience of interacting with a computer for the first time in their lives, to help their children with their school obligations. Many others did not even dare to interact with the computer. They were lost in how they should help their children. It was a completely new situation for everyone. In many cases, the older children became the guardians of the younger siblings, placing much responsibility on them. All of the above brought a lot of stress, depression, and chaos to families. These stressful situations caused many cases of domestic violence.

The farmworker community needs follow-up, time, and patience from organizations to adopt changes and achieve results. The MSAW Program since the start of the COVID-19 pandemic has witnessed a total lack of communication with the agricultural community about the pandemic. Media communication and print media in English were abundant, in Spanish, some information resources were found, but in the most predominant indigenous languages in the area, Mixteco Triqui, and Awakateco, the information was non-existent.

The MSAW Program team delivered boxes of food, masks, and hand sanitizer to farmworker homes weekly at a time when most people were required to stay home. They realized that the vast majority of the families visited did not know what was happening, especially those families belonging to indigenous communities. The Promotores, using their body language, and explained to them in their indigenous languages what social distancing meant (new concept), the reason of the importance of wearing a mask, and frequent hand washing. In addition, frequent cleaning of shared places, such as the bathroom, light switches, door handles, etc., was also emphasized.

Being aware of the importance of educating the agricultural community about COVID-19, and knowing that appropriate materials were not available to them, the MSAW

Program designed easy-to-understand popular education material for the community, graphically recreating distancing protocols, symptoms, what to do if you have symptoms, and where to go to get tested. Once the vaccine became available, additional material was developed about the available vaccines, possible side effects, and where they could be obtained.

These one-on-one meetings in indigenous communities by Promotores de Salud have been and continue to be a key determinant for members of these communities to be informed and, more importantly, to receive the COVID-19 test and vaccine.

Taking into account the beliefs and health practices of indigenous communities which are based on traditional healers and home remedies, and the tendency not to seek care in health centers and go to the emergency room as a last resort, allows us to understand why it is much more difficult to reach this community with health services related to COVID-19 compared to other ethnic groups.

Farmworkers experience many barriers. They lack preventive health practices, mentioned above, due to their culture such as annual exams. Many of the words, concepts, or methods used to describe health practices do not exist in some of these languages. All of this constitutes tremendous barriers to discussing vaccines with them. The word vaccine is unknown, for some of them this could be an injection; however, an injection is not a vaccine. Some women in these communities may mistake the quarterly contraceptive injection for a vaccine.

All the misinformation that the community receives from multiple sources creates misunderstandings. The power dynamic exerted over them by some people representing local agencies does not help either; creating more intimidation than they already experience. The way they protect themselves is by remaining silent, and that does not mean they do not have a lot to say.

Thanks to the pandemic, many local organizations have become actively involved with the farmworker community. The Promotores de Salud have worked with Public Health in different initiatives; Indigenous language translations embedded in videos used to

guide the community on how to navigate COVID-19 testing and vaccination sites, reaching the community at non-exclusive COVID vaccination events, and bringing resources to Latino neighborhoods.

The roots of vaccine insecurity for the vast majority of indigenous farmworkers we have reached go beyond this pandemic. Things will not change overnight. This is more than just hesitancy about vaccines; it is about language, culture, worldview, collective trauma, and current and past barriers.

As local agencies and organizations serving these communities, we are obliged to facilitate access to our services by implementing new outreach strategies.

Annex A

SDOH Survey

Información Demográfica

1. ¿Usted ha vivido o trabajado en este lugar por los últimos 24 meses / 2 años?

- a. Si
- b. No

Si no, ¿en dónde ha vivido o trabajado en los últimos 24 meses/ 2 años?

2. ¿Cuál es su sexo?

- a. Hombre
- b. Mujer

3. ¿Cuántos años tiene usted?

- a. 18-23
- b. 24-28
- c. 29-32
- d. 33-38
- e. 39-45
- f. 46-55
- g. 56+

4. Es usted:

- a. Soltero/a
- b. Con pareja (unión libre/juntado/a)
- c. Casado/a
- d. Separado/a
- e. Divorciado/a

f. Viudo/a

5. ¿Cuáles lenguajes habla usted? (*marque todo lo que aplique*)

- a. Español
 - b. Mixteco
 - c. Triqui
 - d. Awakateko
 - e. Chalchiteco
 - f. Mam
 - g. Otro, ¿cuál?
-

6. ¿Dónde nació usted?

a. Pueblo/Aldea:

b. Ciudad:

c. Distrito/Municipio:

d. Estado/Departamento:

e. País:

7. ¿Cuántos hijos tiene usted?

- a. 0 (vaya a la pregunta numero 12)
- b. 1
- c. 2

- d. 3
- e. 4
- f. 5+

Preguntar solo si tiene hijos

8. ¿Cuáles son las edades de sus hijos?

(marque todo lo que aplique)

- a. 0-5
- b. 6-10
- c. 11-15
- d. 16-20
- e. 21+

9. *Preguntar solo si pregunta 8 tiene a, b, y/o c marcadas*

A. ¿Puede pagar por el cuidado de sus hijos pequeños, cuando necesita este servicio?

- a. Nunca
- b. A veces
- c. Siempre
- d. No pago por este servicio

B. Quien cuida a sus hijos pequeños cuando

necesita de este servicio?

- a. Pariente (familia)
- b. Conocido/a
- c. Ellos se cuidan solos
- d. otro:

b. No

c. No están en edad para ir a la escuela

Preguntar solo si tiene hijos mayores de 18 años

11. ¿Alguno de sus hijos mayores de 18 años están estudiando o estudiaron después de graduarse de la preparatoria/diversificado?

- a. Si
- b. No

12. ¿Cuántos años fue usted a la escuela?

13. Usted puede en español:

(marque todo lo que aplique)

- a. Leer
- b. Escribir
- c. Ninguno

Preguntar solo si habla un dialecto

14. En su dialecto/idioma puede:

(marque todo lo que aplique)

- a. Leer
- b. Escribir
- c. Ninguno

15. ¿Puede tener una conversación en inglés?

- a. Si
- b. No

Educación

10. ¿Sus hijos menores de 18 años van a la escuela?

- a. Si

Economía y Recursos

16. ¿Está trabajando actualmente?

- a. Si
- b. No
17. ¿En que trabaja usted (o su familiar) ahora mismo?
- a. Campo/Cultivos
- b. Planta de Procesamiento/Empaque
- c. Viveros/ Nursery
- d. Otro (¿cuál?)

18. ¿Le gustaría hacer un trabajo diferente del que hace actualmente?
- a. Si
- b. No
- Si, si, ¿cuál?

- ¿Qué le impide hacer el cambio?

19. ¿Cuál es su ingreso al año?
- a. \$0
- b. \$1-\$15,000
- c. \$15,001-\$20,000
- d. \$20,001- \$25,000
- e. \$25,001- \$30,000
- f. \$30,001- \$35,000
- g. \$35,001- \$40,000
- h. \$40,001- \$50,000
- i. \$50,001+
- j. No se
20. ¿Actualmente, recibe usted alguna de las siguientes ayudas? (*marque todo lo que aplique*)
- a. Estampillas de comida (SNAP)
- b. WIC
- c. Ayuda con el pago de la vivienda (*la renta*)
- d. Ayuda con el pago de la electricidad
- e. Otro:

- f. Ninguna de las anteriores
21. ¿Tiene usted acceso a internet?
- (*marque todo lo que aplique*)
- a. En su teléfono
- b. En su Casa
- c. No tengo acceso a internet
22. En el último año, ¿Cuáles de las siguientes cosas usted necesito y no pudo conseguir? (*marque todo lo que aplique*)
- a. Comida
- b. Ropa
- c. Servicios (ej. agua, gas, electricidad, etc.)
- d. Cuidado de niños
- e. Celular activado
- f. Medicina y/o atención médica
- g. Cuidado de salud mental
- h. Cuidado dental
- i. Cuidado de los ojos
- j. Otro (*por favor escriba*)

- k. Ninguna de los anteriores

23. La falta de transporte le ha impedido llegar a: *(marque todo lo que aplique)*
- Citas médicas/dentales/salud mental
 - Trabajo
 - Reuniones comunitarias
 - Compras de cosas básicas
 - Ninguna de las anteriores
24. ¿Actualmente, cuál es su situación de vivienda?
- Vivo en vivienda para trabajadores agrícolas
 - Rento una vivienda
 - Comparto una vivienda en renta con otras personas
 - Pago una hipoteca (préstamo de casa)
25. ¿Está preocupado/a por perder su vivienda?
- Si ¿Por qué?

 - No
26. Piense en el lugar donde vive. ¿Tiene problemas con alguno de los siguientes? *(marque todo lo que aplique)*
- Plagas como cucarachas, hormigas o ratones
 - Moho/humedad
 - Tuberías o pintura en mal estado/con plomo
 - Techo roto/ el agua entra
 - Falta de calefacción
 - La estufa no funciona
- No hay un espacio asignado para la cocina donde hay un lavaplatos
 - Alfombra/tapete/carpeta vieja y contaminada
 - No hay refrigerador
 - No hay baños privados
 - Baños sin mantenimiento
 - Faltan detectores de humo o no funcionan
 - Fugas de agua
 - Ninguna de las anteriores
 - Otro ¿Cuál? _____
- Ambiente alimenticio**
27. ¿Tiene un horario específico para comer todos los días?
- Si
 - No, si no, ¿por qué no?

28. ¿Hay ciertos alimentos que nunca come?
- No
 - Si ¿cuáles son?

29. ¿Cuántos vasos de agua toma al día regularmente?
- 0
 - 1-2
 - 3-4
 - 5-6
 - 7-8

f. 8 +

30. ¿Cuántas latas de bebidas energéticas toma usted al día regularmente?

a. 0

b. 1-2

c. 3-4

d. 5+

Salud y estilo de vida

31. ¿Usted tiene un seguro médico?

a. Si

b. No

c. Temporal por el embarazo

d. No se

32. ¿Cuándo fue la última vez que vio a un médico?

a. Menos de un año

b. 1 año

c. 2 años

d. 3 años

e. 4 años o +

f. Nunca ha visto un médico

33. ¿Cuándo fue la última vez que vio un dentista?

a. Menos de 1 año

b. 1 año

c. 2 años

d. 3 años

e. 4 años o +

f. Nunca ha visto un dentista

34. ¿Qué médicos especialistas ha tenido que ver en los últimos 5 años? *(Si no sabe que es un médico especialista, no explique y escriba exactamente lo que la persona diga)*

35. ¿Usted sabe que es el VIH/SIDA?

a. Si

b. No *(explicar lo que significa: El VIH es un virus que se transmite sexualmente y ataca el sistema inmune (sistema de defensa). Si el VIH no se trata, puede causar una enfermedad que se llama SIDA. Actualmente no existe una cura. Una vez que las personas contraen el VIH, lo tienen de por vida. Pero con la atención médica adecuada, el VIH se puede controlar.)*

36. ¿Regularmente, cuántas horas duerme cada noche?

a. Menos de 4

b. 4-6

c. 6-8

d. 8-10

e. 10 o +

37. En el último mes, aparte de las actividades del trabajo ¿cuántos días, en promedio, a la semana hizo ejercicio moderado *(como caminar rápido, correr, bailar, nadar, andar en bicicleta u otras actividades similares)?*

a. 0 días

b. 1-2 días

- c. 3-4 días
- d. 5-6 días
- e. 7 días

38. ¿Usted tiene alguna de las siguientes enfermedades? (*marque todo lo que aplique*)

- a. Diabetes tipo 2
- b. Presión alta
- c. Alto colesterol
- d. Asma
- e. Problemas respiratorios
- f. Enfermedad del corazón
- g. Otro: _____
- h. Ninguna de las anteriores

39. ¿Usted sabe que es una vacuna?

- a. Si
- b. No (*explicar: Las vacunas se inyectan/ponen en el brazo. Ayudan a su sistema inmune (sistema de defensa) a pelear contra algunos virus que causan enfermedades y así defenderse.*)

40. ¿Alguno de sus hijos tiene alguna enfermedad?

- a. Si, (*escriba la enfermedad*)

- b. No
- c. No se
- d. No tengo hijos

41. ¿Sus hijos han recibido todas las vacunas recomendadas para su edad?

- a. Si
- b. No, ¿Por qué no?

- c. No sé
- d. No tengo hijos

Salud Mental

42. Estrés significa una situación en la que una persona se siente tensa, inquieta, nerviosa o ansiosa, o no puede dormir por la noche por preocupación o porque tiene muchas cosas en su mente. ¿Siente este tipo de estrés en estos días?

- a. No
- b. Algunos días
- c. Muchos días

43. ¿Comparte tiempo y habla con frecuencia con su familia, amigos u otras personas que son importantes para usted? (*Por ejemplo, visitar familiares o amigos, hablar con amigos por teléfono, ir a la iglesia*)

- a. Si
- b. No
- c. No me gusta

44. ¿En los últimos días se ha sentido angustiado/a o preocupado/a con palpitaciones rápidas de corazón, sudando, preocupación excesiva o intranquilo/a?

- a. Si
- b. No

45. Durante las últimas 2 semanas, ¿con qué frecuencia se ha sentido molesto por alguno de los siguientes problemas?

A. ¿Poco interés o placer en hacer cosas?

- a. Nunca (0)
- b. 1-2 días a la semana (1)
- c. Más de la mitad de la semana (2)
- d. Casi todos los días (3)

B. ¿Se siente decaído(a), deprimido(a) o sin esperanza?

- a. Nunca (0)
- b. 1-2 días a la semana (1)
- c. Más de la mitad de la semana (2)
- d. Casi todos los días (3)

**(Si obtiene 3 o más cuando agrega las respuestas a las preguntas 44A y 44B, la persona podría necesitar servicios de Salud Mental. Preguntar al final de la encuesta si está interesado(a) en tener una cita con un consejero.)*

Uso de sustancias

Las siguientes preguntas se relacionan con el consumo de bebidas alcohólicas, cigarrillos y otras sustancias. Algunas de las sustancias son recetadas por un médico (como medicinas para el dolor). Otras preguntas son sobre el uso de otras drogas, es importante que sepa que solo preguntamos acerca de esto, para identificar los servicios comunitarios que pueden estar disponibles para ayudarlo/a.

46. ¿Cuántas veces en los últimos 12 meses ha tomado _____ bebidas alcohólicas al día? (hombres) 5 o más y (mujeres) 4 o más

(Una bebida equivale a una lata de cerveza)

- a. Nunca
- b. Una o dos veces
- c. Mensualmente
- d. Semanalmente
- e. Diariamente o casi a diario

47. ¿Con el fin de tener más energía para trabajar, sentir menos cansancio, y/o dolor muscular, usted acostumbra a tomar alguna pastilla(s) que le ayude con esto?

a. Si ¿cuál pastilla(s) toma?

b. No

48. ¿Cuántas veces en el último año ha usado medicamentos de receta médica en una manera en la que no debe usarse?

- a. Nunca
- b. Una o dos veces
- c. Mensualmente
- d. Semanalmente
- e. Diariamente o casi a diario

49. ¿Cuántas veces en el último año ha consumido drogas (heroína, cocaína, anfetaminas, alucinógenos, otras)?

- a. Nunca
- b. Una o dos veces
- c. Cada mes
- d. Cada semana
- e. Diariamente o casi a diario

50. ¿Cuántas veces en el último año ha consumido marihuana por razones no médicas?

- a. Nunca
- b. Una o dos veces
- c. Cada mes
- d. Cada semana
- e. Diariamente o casi a diario

*Seguridad

51. ¿Se siente seguro/a en su actual vivienda?

- a. Si
- b. No, si no, ¿por qué no?

52. ¿Se siente seguro/a en su actual trabajo?

- a. Si
- b. No, si no, ¿por qué no?

53. En el último año ¿alguien de su familia le ha lastimado físicamente, insultado y/o amenazado/a?

- a. Si
- b. No
- c. No se
- d. Elijo no responder a esta pregunta

54. En el último año, ¿le ha tenido miedo a su pareja o expareja?

- a. Si
- b. No
- c. No se
- d. No he tenido pareja en el último año

e. Elijo no responder a esta pregunta

La Pandemia (COVID-19)

55. ¿Usted ha recibido la vacuna contra el Coronavirus?

a. Si

i. ¿Qué le motivo a ponerse la vacuna?

b. No

ii. ¿Por qué no?

56. ¿Qué ha escuchado acerca de porque otras personas están rechazando la vacuna?

57. ¿Quién le dio información relacionada al Coronavirus por primera vez (*Información de los síntomas, que hacer si los tiene, a donde ir, etc.*)?

58. ¿Ha recibido información sobre el Coronavirus en su idioma?

a. Si, ¿a través de que medio?

b. No

Annex B

Key points of Semi-structured interviews with Nurses and Health Care assistants

Q1. How do you think the indigenous community perceives the services they receive at the clinic? Why?

- Members of these communities feel comfortable coming to the Sea Mar clinic because, one way or another, even if no one speaks to them in their language, at least they will find many people who can talk to them in Spanish. Considering that for many members of the farming community, Spanish is their second language, which is a big help. There is no bilingual staff in other local health care organizations, such as local clinics other than Sea Mar and hospitals. Patients in these communities recognize that Sea Mar makes a big difference in this aspect of service.
- Patients perceive the health care service poorly because they arrive at a medical appointment with multiple ailments, they want to be cared for and listened to, but the doctor is limited in time. Only 15 minutes are dedicated to attending to multiple problems for a single patient. This also shows that the indigenous community and this is widespread, is not in the habit of seeing a regular doctor, most of them come to the clinic with very advanced health problems, or in response to a follow-up appointment because they went to the emergency room.
- The indigenous community receives with doubt and distrust services offered to them. A lack of understanding of health science

generates distrust and the language barrier is an ingredient against them.

- Pregnant Indigenous women see the fact of having to come for check-ups so often as extreme, especially at the end of the pregnancy. They do not understand why they must go once a week if the doctor follows the same routine every time.
- Frequent visits to the doctor for a newborn is a routine that needs to be established with parents. This is new for them because, in their countries of origin, visits to the doctor are very sporadic.
- Many of our indigenous patients have never seen a doctor; for this reason, it is difficult for them to see how important these visits are. We should explain that this is the only way to see how the children are developing or the pregnancy is evolving.
- Indigenous patients require a lot of dedication, more explanations, repetition, feedback, and visits that take more time than other patients do.
- Sometimes women come to a doctor for their first prenatal visit until the 3rd or 4th month of pregnancy. Recently a woman had her first visit at week 28.
- They go to the doctor for illness or pregnancy. Women say my stomach is starting to show, or I am already feeling the baby move.

- A woman arrived almost at week 30, and she thought she had a worm in her stomach, and it was her second baby.

Q2. Have you been able to establish a relationship with these patients? If Yes, how so? If no, why not?

- Yes, identifying myself with them and speaking their language clearly in simple language, describing a concept or situation that the doctor is communicating to the patient when there is no word in their language for this, or showing images. I developed some visual materials that helped me do my job better.
- When they speak Spanish, yes. They are courteous. You have gained some of their trust because they start asking questions. It is noticeable in the tone of the conversation, there is more fluidity, and there is a dialogue.
- Trust is based on speaking to them with respect, and respecting the fact that they can make the decisions, they want, making sure that they have access to information to make the best decisions regarding their health.
- Trust is something that develops little by little, it takes time to build trust with them, but once this has been achieved, patients believe and trust what you tell them.

Q3. Do you think that patients from indigenous communities face bigger challenges and difficulties than other patients? If yes, go to the next question. If no, explain why not.

- Undoubtedly, just not speaking the language. They cannot communicate in English and many in Spanish either. They do not have transportation, they do not have resources, and they do not have the

education to understand the system. It is very difficult for them. They are at a significant disadvantage compared to other patients.

Q4. How do you think you can help these patients minimize the challenges and difficulties they face accessing health care services?

- Hire more bi-cultural staff who can be connectors between providers and patients.
- Through Programs such as Promotores de Salud that serve as ambassadors between these communities and health services. Programs that facilitate the processes, what to do, how to do it, etc. This changes everything, having an intermediary between the Community and the systems.
- Taking the time to listen to their needs connecting them with people who can help them, in case we cannot do so directly.
- The main one would be to mitigate the transportation barrier.
- Educate about how to navigate the pharmacy system and how to claim their medicines. They do not understand that the medication prescribed to them will be in the pharmacy or that some medication have refills, and for that reason, they must return to the pharmacy. They do not understand any of this. They do not understand that sometimes the medicine reaction will take one, two, or three weeks to take effect, depending on the medication. The importance of them having the means to get to the places they need to go to get their things.

- Delivering the physical, printed prescription and following up through a call. It is key to do this.

- Ask the patients to go back to the clinic so they can take the bottle of medicine, then the nurse can circulate on the label where it says how many more times they can go back to the pharmacy, in case of a refill. In addition, highlight and write for them what it is for, for example, *this is for the stomach*.

- Bring the patients with long treatments a month later to ensure they are taking the medicine and find out how the treatment is progressing.

Q5. How have you helped patients who face more barriers than others face, feel more comfortable?

- Offer education for providers and clinics that care for patients from these communities—involving more interpreters who can facilitate the processes. Someone who can accompany them, who can explain and teach them new skills. The community has different customs, and when they arrive here, they have to start doing things in a very different way. A person who facilitates the experience will help break down barriers and minimize the challenges they face.

- “Identifying ourselves with them gives to the patient confidence. In addition, being accompanied by someone they can communicate with during their visits who knows and understands their culture makes it more likely that patient will start and finish their treatments because there is understanding. The reason why patients from these communities do not follow the treatment is that they do not understand the importance of doing the treatment and/or how to do it. We have seen it. I have many examples: Patients have come back

to tell me. One of the patients that I remember had urinary incontinence. The patient explained the discomfort of this disease, especially being a farmworker where there is no bathroom nearby and going to the bathroom so often constitutes losing time from work. Sometimes the need won out and she would arrive feeling very embarrassed. The doctor referred the patient to a specialist within Sea Mar, after the appointment, the patient asked me about the visit to the specialist, she had many doubts about it and I had the opportunity to explain what type of specialist this was and how the specialist would be able to help. After a few weeks, the patient came back, just to thank me and tell me that thanks to the information she received, she had found the treatment and the solution for her illness”.

- The tone of voice can make a patient feel comfortable or uncomfortable.

- Give them simple directions without giving orders because they get even shyer and do not come back.

- Cultural humility is needed to treat these patients fairly.

Q6. Is there something in particular that prevents you from carrying out your duties when you are attending these patients? If yes, please provide an example.

- The language and the very limited time that we have to dedicate to patients is insufficient to answer all the questions and satisfy the doubts that some have during a medical appointment.

- The time is very limited, being the only HCA in the clinic. A prudent time should be at least half an hour. Sometimes, additional explanations are needed, especially when the patient has to do labs. If they should

come fasting, what time they should come, or for a follow-up appointment about what will happen after the results arrive, or why we have to wait to see how it reacts to the medicine for the next appointment. Briefly describe the processes in detail. Then more questions come from the patients, which is no longer part of the appointment time. Many leave with half the information.

Q7. Is there something you would like to do for these patients but cannot because it is not part of the system or protocol? If yes, please provide an example.

- There are situations where we cannot do what we would like to do to help the patient. For example, the patient is the woman, but the husband is the one who responds and decides whether the wife takes the treatment or the medicine. She cannot decide for her own health, nor can she enter the medical appointment alone; this is something cultural.

- The “machismo” is very common in these communities. The female patient speaks only if the husband approves. When the patient is asked something, she looks at the husband, waiting for acceptance to be able to give the information. We are aware of this dynamic; it is obvious. Clearly, this situation limits us a lot, sometime the patient does not accept the treatment, or decides not to receive an exam because her husband does not approve it.

- Some patients are victims of domestic violence. If they mention it during the medical appointment, we can report it; otherwise, not, even if we see the evidence of the bruises.

- Not having the necessary information from the patients to be able to help. The language and cultural barriers are significant impediments for health workers

to do the job thoroughly. We are very limited.

- The lack of interpretation is what prevents provider services to be at good standard. The system has no interpretation services in indigenous languages.

- “The limitation is not being able to go to the places where people are; it is better for them to receive services in their place instead of asking them to go where the institutions are. My institution (Public Health) does not let me go where people live. It is part of the protocol.”

- “The impediment is in the language. I do not have access to qualified interpreters in those languages. Many people provide interpretation services, as family members, for example, and they do it well. However, it is different from a qualified interpreter who is a trained professional person who understands their duties, what to do and what not to do, ethics, confidentiality; it is different. I would like to see if there are programs that facilitate training for indigenous language interpreters to provide a high-quality service with dignity for this entire population and be adequately compensated people. I have seen many times competent people who speak different languages asked to work without payment, which is not fair. I would like to see in our region programs developed to train qualified interpreters who communicate in a culturally appropriate way.”

- “Patients wait hours for the arrival of the driver who does them the favor of transporting them, sometimes a neighbor or family member. Solving the transportation issue for people who do not have a way to get to their medical appointments or go to the pharmacy to

claim the medicine would be significant progress.”

Q8. How could the experience of accessing medical services improve for these patients?

- “The best way to improve the service experience for this community is to train the people interacting with these patients/clients; about their cultural perspective; thus, they can understand that there are cultural and linguistic differences that exist; and be aware of that. Treat members of these communities with respect. It is essential to understand that sometimes people tend not to interact or not to answer, not because they have nothing to say, but because they feel uncomfortable in that dynamic, where one person has all the power. It is perceived in that way, so they do not say anything, even if they have a lot to say.”
- Talking to them, answering questions, and offering information that could be key to improving their experience and connecting them with other people who can do the same, but with linguistic ability, trusted people.
- Having more staff in the clinic that can focus on these patients.
- Education about being consistent with their medical appointments, having continued care, it is a concept of nurturing the migrant community. Teach them about prevention.
- Facilitating popular education so that they understand the system.
- Providing interpretation services in the native languages of these culturally humble patients.

- Facilitating transportation.
- Providing home delivery of medicines.

Q9. If you had an opportunity to change something about the medical treatment that indigenous communities receive what would be?

- “I would like to see more recognition of those cultures, know how to work with different people, and have linguistic access because I always think about indigenous women who have to go to the hospital to give birth. No one speaks to them in their language. Even worse, during the pandemic that few people can accompany them, it is an inhuman experience. As a woman, I have had my children, and I know how much support one needs at that time and to be there, and no one can tell if things are going well, if it is almost done or once the baby is born, To be able to say, your baby is fine, we are just examining your baby. That is something that I am passionate about. I want our county to have a place where we can serve indigenous women in their delivery, recognizing their culture and language so that they feel supported.”
- Make sure patients can apply to an assistance program first and wait long enough to find out if they are eligible before making referrals. Meanwhile, see other alternative options.
- “In addition, as nurses, we must give the patient the resources we know, such as sharing information about discounts for medicines in some pharmacies.”
- “The fact of not having health insurance prevents labs or other tests from being ordered because it is not known if the person will be able to pay for them, so they are given a certain medicine to see if it

helps. However, when they arrive at an emergency room there, they are not asked about whether they want an exam or not; they simply do it because the patient's life is at risk. Whatever needs to be done, they do it without thinking about what the patient will do with that account.”

Q10. Do you think these patients are treated differently than other patients? If yes, how?

- “Generally, we try to give equal treatment to all patients; however, some patients need more help than others, and that is when I notice that for some people, it is not easy to give that extra help. Comments like this: why do I have to make an appointment for this patient's ultrasound? Why cannot the patient do it himself?”
- “Unfortunately, yes, due to lack of understanding, patience and time. When people do not speak or just raise their shoulders, people interpret these signals in a wrong way, rather than taking the time to wonder why this person reacts like this.”
- “The medicine prescription may differ for two patients with the same medical condition. Some medications are better than others are. It all depends on whether the patient has health insurance and the economic capacity of the patient, seen from the doctor's perspective, sometime.”

Q11. Have you seen inequity in the way indigenous patients are treated? If yes, please provide an example.

- “They should have the same rights as other people to have the information, but they do not have it. I would like to provide an example, due to the low level of literacy, some people from this community could not read, so someone reads for them in order for them to have the right to make

their own decisions about their health. In this case, I am referring to filling out a consent for surgery. The truth is, I do not think they are receiving the complete information. They only sign because they were told to sign. I feel that there is inequity because indigenous communities do not receive all the information about their health. It is very important that they know what will happen.”

- “As interpret I have seen it, the doctor does not take the time to make sure that the person understands and has answered all the questions as indicated by the law, it is unfair. Like when women have surgery, a hysterectomy, and they do not understand the purpose of this operation. Later, they find out that they no longer have a uterus and cannot have more children; they did not know why; they thought it was something else. Perhaps the hysterectomy has been recommended to them, and according to the doctor, they have been told about the benefits and the things to consider, the conversation is closed, do you want it or not? And in the end, they sign. I think that can happen. Misunderstanding about medical processes with this community is frequent.”

- “As a nurse it is my responsibility to give that extra help, such as printing a medical prescription or printing a photo of the medicine with the place where it is cheapest to get it, because it is information that we already know, it does not cost us anything to share it. Definitely It is of great help to the patients, especially in these communities that do not read or write, visual things help them understand better. It is not preferential treatment, as some colleagues think. Many colleagues say that doing something for patients is not teaching them to be autonomous. I understand that reflection. However, what happens if, for some people, the situation is too critical; and there is no time to take

them in continuing education? As I mentioned before, we have 15 minutes with them, and we do not know if we will see them again, so we must do what we have to do for them when we have the opportunity to do it.”

Q12. Within the farmworker community, there are diverse groups. Which of these groups are you familiar with and what stands out to you about their health practices and beliefs?

- Mixtecos, Awakatecos, and Mams.
- We have diverse groups from southern Mexico and Guatemala. I do not know the languages they speak.
- “Many people prefer to receive massages. They think that there is a thread that connects and controls the whole body, and there are "sobanderos" (traditional healers who specialize in massages) who manage to help people with high blood pressure and sugar level through these massages. Many maintain the traditions of home remedies. Regarding women's care, some people know how to accommodate a baby in the mother's womb when it is in the wrong position. There was a case of a woman who entered the hospital with a relative specialized in this technique; the doctor told the mother that she would wait 45 minutes to see if the baby changed the position otherwise, she would have to do a C-section. The patient was left alone with the “sobandero”, this person did the massage, managed to change the position of the baby and this patient had a natural birth.”
- They like to use natural medicines, like tea. They have beliefs about hot and cold and about bundling up well.
- “They doubt the medical science we have here, so being able to explain why sometimes we recommend a certain thing

is important. Still, at the end, I think it is valid to respect their decisions, but what they deserve is to have all the information.”

- Indigenous patients do not believe that a cream can help relieve pain; everything has to be with pills or something taken because they think the only way to heal is from the inside out.

- When patients arrive with flu symptoms they are not prescribed any medication. Patients in these communities ask for a prescription of syrups, even for children under one year of age, and this is not the correct way to treat them. Adult patients expect that they will receive a prescription for antibiotics when they have flu.

Q13. Considering the population's barriers, what do you think is the best way a patient from an indigenous community could evaluate the quality of services they receive at the clinic?

- The only way to know is by asking the patient directly after receiving the service. Having an established trust relationship helps them express how they feel. This can be done only one on one and verbally.
- “The community needs to have a voice to make changes and be heard. Some groups are interested in knowing that information, and there are groups that definitely do not care. If community leaders could settle down, who can have fluid communication with them and speak for them, which would be ideal. They will hardly be able to represent all of them. Still, at least the community's suggestions would reach certain interested groups and bring information to the community so that it is a two-way communication. “
- We need more multicultural people with a linguistic variety.

Annex C

Oral Health and Access to Dental Care among Migrant and Seasonal Agricultural Workers in Skagit and Whatcom Counties, WA.

Bridging The Gap: Mobile Dental Clinics for Migrant and Seasonal Agricultural Workers

Skagit and Whatcom County are major contributors to state and federal crop production¹. Migrant and Seasonal Agricultural Workers (MSAW) play a crucial role in maintaining the region's productivity, with Washington ranking 5th in MSAW employment². Farmworkers must maintain optimal health to carry out the demanding work crucial to Washington's crop production. Unfortunately, Migrant and Seasonal Agricultural Workers (MSAW) encounter a multitude of unique obstacles when seeking essential healthcare services³. In response to this need, Sea Mar Community Health Centers initiated the Promotores de Salud Program in 2009. This program focuses on serving the local agricultural community through mobile health clinics strategically stationed at migrant camps, churches, community centers, temporary farm worker housing, and shelters. Commencing in 2014, the Promotores de Salud Program expanded to include annual mobile dental health services.

These year-round mobile dental clinics provide a comprehensive array of critical services, encompassing prescription filling, tooth extractions, fillings, routine dental cleanings, and specialized procedures, such as root canals and molar extractions, which are infrequently available in rural settings. Among these, tooth extraction to address severe tooth decay emerges as the most prevalent treatment. The high incidence of dental decay within the farm worker population remains a pressing concern. In many instances, patients face a difficult choice: opt for a root canal procedure, followed by subsequent dental appointments to secure a dental implant, or select extraction to prevent the infection from spreading to adjacent bones or teeth. Due to financial limitations and time constraints, nearly all MSAW patients tend to choose the latter option.

Between 2014 and 2022 the MSAW Promotores Program conducted 72 mobile dental clinics delivered in part through a partnership with Medical Team International (MTI) along with the assistance of volunteer dentists and dental assistants who collaborated with Sea Mar's dental

staff. From 2014-2022, 784 individuals received dental care at no cost, out of which 766 were farm workers. Of these, 52% were migrant farm workers (404), and 46% were seasonal farm workers (362). The remaining 2% were homeless individuals who were not farm workers (18). Of 784 individuals, 45% were members of indigenous communities. As of 2023, the financial support for these clinics is diminishing - significantly reducing the number of dental clinics per year and putting the continuation of this essential service at risk.

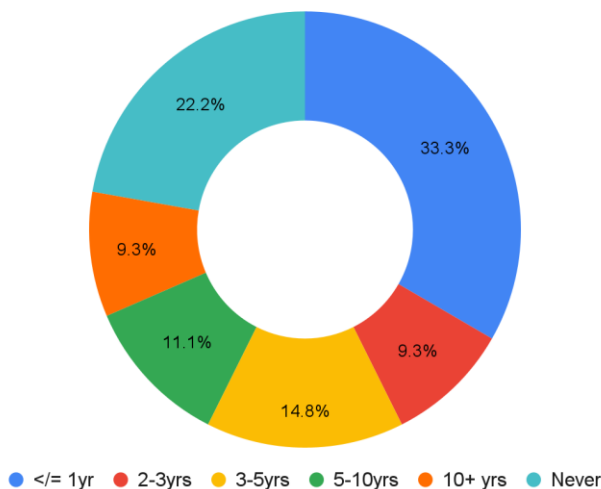
Assessing Dental Health Access among MSAW: A Survey of Utilization and Unmet Needs

To highlight the ongoing need of this population, a dental health study in the form of a 10-item survey was administered to patients across 3 MSAW mobile clinic sites in Summer 2023 (dental services were not being provided). The survey was verbally administered in Spanish while patients awaited their medical appointments. Patient participation was entirely voluntary, anonymous, and completed in private. The data collected sheds light on the dire state of dental health care needs among MSAW in Skagit and Whatcom Counties.

Key Finding: Low Dental Health Service Utilization and Access.

Only 33% of MSAW aged 18-67 visited a dentist in the past year - significantly lower than the national average of 65%⁴. Nearly 43% of MSAW aged 18-67 had not received dental care in over 5 years, with 22% having never been to the dentist (Figure 1).

Years since last dental visit
MSAW aged 18-67 in Skagit and Whatcom County, WA. 2023.

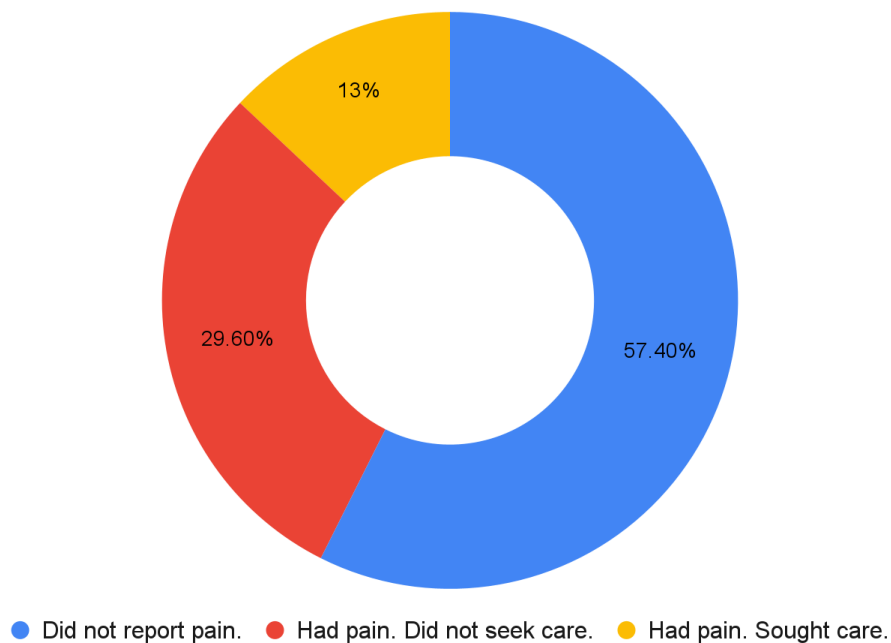


Key Finding: High Rates of Unaddressed Tooth and Gum Pain.

Approximately 43% of MSAW aged 18-67 reported experiencing tooth or gum pain in the last 2 years. Despite this high prevalence of pain, only 30% of those reporting oral health issues had visited a dentist in the past 2 years, indicating a concerning gap between dental care needs and utilization (Figure 2).

Percentage of MSAW aged 18-67 reporting significant tooth/gum pain in last 2 years.

Skagit and Whatcom County, WA. 2023



Recommendations to Address Dental Health Disparities among MSAW

Ensuring the continued availability of mobile dental health clinics is a critical necessity. This method of service delivery has been shown to be one of the most effective methods of providing health care to MSAW⁵. The presented data underscores the ongoing dental health challenges faced by Migrant and Seasonal Agricultural Workers (MSAW) in Skagit and Whatcom counties. The low utilization of dental services, and high prevalence of unmet oral health needs, demands immediate action. Increasing financial support for mobile dental services would not only improve the overall health and well-being of MSAW but also effectively address the barriers they encounter, such as long work hours transportation limitations, and significant language barriers. By offering comprehensive care that includes dental services, these clinics can play a

pivotal role in bridging the gap between dental health needs and accessibility, ensuring that this vulnerable population receives the vital care they deserve.

To address the issue of poor oral health practices among this population, it is crucial to implement targeted oral health education programs. MSAW often lack the routine practice of daily brushing, neglect the use of dental floss and mouthwash, and do not attend regular dental visits⁶. These habits, or rather the lack thereof, are often rooted in a lack of early-age oral health education. The development of effective communication within the farmworker community, especially among indigenous groups, is vital for better health outcomes. Our 2022 Social Determinants of Health Report highlights significant challenges: 14% of MSAW respondents are illiterate, with an additional 35% having low literacy levels. Among indigenous farmworkers, just 9% could confidently read and write in their native language, while 30% were fully illiterate⁷. Oral health education approaches should emphasize universal symbols, explanatory graphics, and one-on-one communication with feedback mechanisms. Integrating these approaches into organizational protocols will facilitate the delivery of tailored services to migrant and indigenous communities, ultimately improving dental health outcomes.

Short survey and feasibility studies during mobile clinics have been shown to be particularly effective methods for collecting data on MSAW populations⁵. Conducting follow-up studies in collaboration with dental care providers during mobile clinics would allow for a better assessment of oral disease prevalence, rather than relying solely on self-reporting. This more objective approach would help determine the scope of interventions needed to address oral health disparities among MSAW.

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Carlos Price-Sanchez, MEd. Marcela L. Suarez Diaz. Oral Health and Access to Dental Care among Migrant and Seasonal Agricultural Workers in Skagit and Whatcom Counties, WA. 2023

