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Fresh foods are offered as part of the popular free food market.

Photo courtesy of Virginia Garcia.

Hunger Hits Those Who Produce Our Food

Jillian Hopewell, MA, MPA, Director of Education and Communication, Migrant Clinicians Network

There is a profound irony in the fact that many agricultural workers in the United States suffer from food insecurity. Those who plant, cultivate, and harvest the food we all depend on, face economic, social, and logistical challenges that impact their ability to access sufficient food for themselves or their families.

The United States Department of Agriculture (USDA) defines food insecurity as the lack of consistent access to enough food for an active and healthy life.[1] Food insecurity does not exist in a vacuum; it is closely linked to a number of overlapping social issues such as inadequate housing, poverty, social isolation, and lack of access to transportation.

While there are no national studies on food insecurity among agricultural workers, regional studies show alarming findings among that population. A 2011 study in Georgia found that 62.83% of migrant agricultural workers surveyed did not have enough food.[2] Another study from California revealed that agricultural workers, and especially those who lack authorization to work in the US, depend on emergency food as their main food source.[3] A 2007 study in Fresno County, CA found a 45% prevalence of food insecurity among farmworkers.[4] The latest National Agricultural Worker Survey (NAWS) data shows that the average farmworker household incomes ranged from $20,000 to $24,999. According to the NAWS survey, about 30% of agricultural worker families live below the poverty line, almost three times the percentage of the US as a whole.[5] The onslaught of the COVID-19 pandemic has noticeably increased food insecurity in low-income communities across the country. In March 2021, Feeding America "projects that 42 million people (1 in 8), including 13 million children (1 in 6), may experience food insecurity in 2021." Their findings showed that those who were already at risk of food insecurity experienced greater hardship during the pandemic. Prior to the pandemic, food insecurity was more likely to be experienced by Black, Latinx, or Native American individuals. Feeding America says that structural racism and poverty were two major drivers of food insecurity among non-white populations in America. After years of decreasing rates of food insecurity, the economic hardships brought on by the pandemic have elevated food insecurity.[6]

MCN's bridge case management program, Health Network (HN), provides a window into some of the challenges facing migrant families. Hannah Lawrence, a MSW candidate working with HN, says that she has seen an increase in the number of HN patients telling her that they do not have

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access to enough food. HN is currently working with a Haitian family in Florida with twin baby girls. The father contacted HN to say they were completely without food. Alma Colmenero, a Prenatal Coordinator with HN, tells of another family who moved from Texas to Florida. The mother recently gave birth and contacted Colmenero to say that she does not have enough money to pay for food or diapers for her baby. HN staff is working with these families to find local organizations that can provide them with food until they are settled and have work.

There are federal programs that can assist agricultural workers and their families with food and other necessities, but these programs do not go far enough to make a significant dent into food insecurity. Farmworker Justice notes that some agricultural workers are eligible for the Supplemental Nutritional Assistance Program (SNAP); the Women, Infants, and Children (WIC) program; and the National School Breakfast and Lunch programs. While these programs are effective in some communities, agricultural workers face a number of barriers to access these food assistance programs. Given these barriers, local assistance programs are critical to help agricultural workers connect with services that provide them with food and other necessities.[7] To better understand the role of local organizations, we offer two case studies of programs that directly confront food insecurity among agricultural worker and their families.

East Coast Migrant Head Start Program

The East Coast Migrant Head Start Program (ECMHSP) was founded to provide early childhood education and other support services for children and families of migrant and seasonal agricultural workers. Their sites are far ranging, as far north as Pennsylvania and down south to Florida. Currently, they operate nearly fifty sites in ten states. Many of their families migrate during the growing season and ECMHSP provides quality services to their children as they move. Recognizing that nutrition and access to food are critical for growth and development, ECMHSP provides breakfast, lunch, and a snack for enrolled children, and sometimes additional meals if needed. ECMHSP staff, supported by dieticians, work directly with parents to create culturally appropriate menus that also help educate families about good nutrition. Where possible, ECMHSP works with local food banks and other social support organizations to offer nutritional support for families. ECMHSP takes a holistic approach to working with families and tries to meet a wide range of needs. They rely on their intake process to determine which families need additional services such as nutritional support.

When the COVID-19 pandemic hit, ECMHSP staff had to quickly adjust their services. Many of their client families were quarantined, scared, and lost their regular employment as well as services they might otherwise be able to utilize. For the children, ECMHSP was shut down between March and June 2020, after which they were able to open and provide regular education services with COVID-19 protocols in place. Some of the families did not feel comfortable bringing their children to the education sites, so ECMHSP had to also provide remote services. During this time, families were not able to access school or other community meal distributions due to their work schedules, and grocery store shelves were empty by the time they were able to shop if they had resources to do so. Realizing that many families depended on their nutritional services, ECMHSP utilized their existing partnerships with local food banks and other organizations to put together weekly meal boxes that included food and other items like diapers and wipes. Because the social service landscape is different in each community, the solutions to provide food required a hyper-local focus and leaned heavily on existing local partnerships including food banks, community health centers, and other service organizations.

According to Renée E. AboAmshe, CHES, who served as the Child and Family Health Manager at the Raleigh Administrative Office through March 2021, sometimes the families ECMHSP serves are reluctant to ask for help. She says that it is critical that they find a member of the community who can serve as a conduit to gain the trust of families. She cited a recent example from Alabama where there was an influx of Swahili-speaking migrant workers. Initially the community was hesitant to apply for services, but after ECMHSP connected with an older community member, that person was able to serve as a gatekeeper and helped to bring people in for services. After gaining the community trust, ECMHSP began to work with local organizations to provide culturally relevant nutrition services to children and their families even as they altered their delivery methods because of the pandemic.

Virginia Garcia Community Health Center

Virginia Garcia Community Health Center was founded as a true grassroots organization rooted in the agricultural worker community. In 1975, a young girl named Virginia Garcia was migrating with her parents from Texas to Oregon to work in agriculture. Along the way, Garcia cut her foot and by the time they reached Oregon it had become infected. Without access to adequate health care, Garcia died from what should have been an easily preventable injury. Her death galvanized the local community in Oregon to organize and open a small community health center. Since that time, Virginia Garcia has grown to see over 52,000 patients a year in five primary care sites, six dental sites, four school-based health centers, a women's clinic and a mobile outreach clinic across two counties in the state.

Virginia Garcia continues to maintain a strong community-based presence and actively partners with other social service agencies in the communities in which it has health center sites. Early on, health center staff realized that access to food was critical to maintain the wellness of their patients. To address hunger, the health center partnered with the Oregon Food Bank. Beginning in 2018, Virginia Garcia and the Oregon Food Bank took their partnership one step further and created Free Food Markets where patients could come and select fresh produce and other food items at locations near or at health center sites. The Oregon Food Bank was also very open to changing the food they offered based on client preferences. For instance, many health center patients wanted more rice, beans, and fresh produce as opposed to canned goods.

Families who might need food assistance are often identified by outreach workers who use the CMS-sponsored Accountable Health Communities Social Determinants of Health (SDOH) screening tool to assess a constellation of needs. Virginia Garcia also employs a warm hand-off method within the clinic where a provider will refer patients to out-

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Resilience is a Zone:

Witness to Witness Supports Managers to Build Equity and Well-Being in the Workplace

By Kaethe Weingarten, PhD, Director of Witness to Witness

The Witness to Witness Program (W2W) celebrated its one year anniversary of working with Migrant Clinicians Network on February 6, 2021, and what a year it has been. However, the relationship goes back longer and it is central to the origin story of W2W. In June, 2018, I heard Deliana Garcia, MCN's Director of International Projects and Emerging Issues, on a panel presentation about work with people at various stages of the detention process and realized that there was a gap in support for the helpers. With Garcia and colleagues from the American Family Therapy Academy we created the early phase of W2W, which was designed to offer one-to-one support for helpers who were themselves stressed by witnessing and assisting those in perilous situations. W2W was based on a model of witnessing, and derived from other programs of support, that I had developed over a period of 25 years.

During the first year of W2W, many of the helpers' needs became abundantly clear. W2W expanded its volunteer cadre to 38 volunteers, six of whom were bilingual, and we added three additional program components: online seminars, peer support groups, and organizational consultation. With the help of MCN, even prior to the affiliation, W2W conducted a few surveys with the hundreds of health care workers who registered for MCN/W2W webinars. The survey data demonstrated that although there were stressors for health care workers at every level within the health care system, supervisors and managers were under particular stress, sandwiched between accountability to those above in the institutional hierarchy at the same time as they were managing staff. These staff members sometimes thought the policies and practices they had to implement were out of touch with conditions on the ground. Once the disasters of the COVID-19 pandemic hit, these stressors rapidly proliferated, and many managers turned to MCN for help.

Managers were also clear that their experiences and that of their staff fit the W2W witnessing model. The model asserts that there are four witness positions — not one. Position One is when a witness is empowered and aware; Position Two is empowered but unaware. Position Three is disempowered and unaware, while Position Four is disempowered and aware. Our positions vary depending on the situations we witness. Position Four may be the most common for health care workers (and others). In this position, a person is aware of what is going on but is either uncertain what to do or lacks the internal or external resources to act exactly as they know to do. This position saps energy, enthusiasm, and resolve. Aware of our witness position, we have a chance to change positions. Sometimes, when we are overwhelmed, we mistakenly believe that relief can come by moving into unawareness, using any number of tuning out strategies, like alcohol, devices, or excessive sleep. However, the only relief and benefit to the person comes from moving into the aware and empowered position, that is, moving up to Position One from Position Three and not over to Position Four.

Managers intuitively understood the impact on their staff of Witness Position Three, even if they didn't have the concept at hand. They could see that Position Three was a factor in staff burnout and attrition. They also clearly understood the importance of creating trauma-sensitive work environments, which are encouraged theoretically and with which they heartily agree.

However, they told us they struggled with a number of dilemmas in implementing such an environment. Among the issues they raised were the following:

- There isn't enough time in the day to deal with feelings if we have to be productive.
- How can I show vulnerability and still maintain my role?
- I'm afraid that talking about distress will amplify my distress.
- I don't have the training to support my staff.
- I know what we need but we don't have the resources to provide it.

We offered concrete suggestions and recommendations, each of which was accompanied with simple and straightforward suggestions as to "how to" do it.

- Institute brief team meetings (see handout on following page).
- Use a buddy system.
- Schedule regular team social events.
- Support the use of a mindfulness app on a daily basis.
- Use easy self-care check-in forms along with coping cards and resource lists.

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- Shift culture from "stiff upper lip" to mutuality.

All of the W2W work is predicated on a few premises that are core to our philosophy and that align with MCN's vision and mission: We work collaboratively with all of our partners; we offer culturally respectful and linguistically appropriate support; we support individual, team, and organizational resilience synergistically; we support sustainable work practices; and we link practice to values. These principles and more allow us to tie our work explicitly to social justice objectives.

All of the underlying principles identified above needed to come into play in the context of the COVID-19 pandemic. By the initial months of the pandemic, W2W was anchored within MCN and could make use of the abundant talent and resources of MCN staff, who was equally committed to practices of social justice. The work expanded, with a more fully developed curriculum for health care workers and other social support service providers, including supervisors and managers. While it would be impossible to lay out the curriculum for the program we provide for managers, I can give you a few glimpses into it. Consistent with the premises above, we work towards equity. We believe that equity is necessary for well-being in the workforce and in the community. A fair distribution of well-being is one measure of equity and managers are in a good position both to see whether well-being is present and to develop practices to support well-being. We use virtual communities of support (VCS) because we believe that open collaborative dialogue among peers is key to workplace change. Recent research supports this conclusion.1 Whenever possible, we also compose our groups with people from different organizations – thus bypassing the distraction of pre-existing workplace dynamics. We have found that it is more likely in these configurations that participants will talk openly with each other, share challenging experiences, and support each other to take effective action within their organizations. The new connections between clinicians create opportunities to try out and refine novel approaches to problems.

Our VCS methodology creates a lived experience of the importance of safe emotional expression. The following two sets of questions provide a glimpse of the kinds of questions that we use to connect past experience to present workplace realities, the kinds of questions that make participation in the W2W experience so meaningful to our participants:

1. Who in your childhood would be least surprised to learn about the kind of work you do now? What did this person observe about you that fits with what you have chosen to do in your work? How does what that person noticed then play out in you today?
2. If it were possible to tell an important person in your life why you do this work, what would you want them to know about your values, what's important to you?

The support offered by peers and the facilitator translates into courage to make change and the concrete suggestions that the curriculum offers provide ideas. We believe that participation in VCS restores self-worth, strengthens appreciation of solidarity, and activates energy for improvements at the organizational level. Burnout and moral injury diminish. Our curriculum promotes the idea that resilience is a zone – not a character strength – that applies to all levels of the organization. This opens entry points for systems change at all levels. With support from their peers in the VCS, new avenues for concrete action emerge.

To learn more about W2W, sign up for updates, access resources, and donate to support the program, visit the Witness to Witness webpage: https://www.migrantclinician.org/witness-to-witness ■

Reference:

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Ideas for team meetings to help with workplace stress

1) Plan to meet daily or weekly for 10-15 minutes at a set time. Be consistent.

2) Preferably convene no fewer than 3 people at a time and no more than 12.

3) Rotate who facilitates the meeting.

4) Go around "popcorn style" (when each person is ready to speak, s/he/they speak) and say one word or phrase to sum up how you are feeling right now about the work situation.

5) Play a two to five minute mindfulness exercise. These are readily available as free apps (Insight Timer, Headspace and Calm all have good tools for this). Listen to this exercise together. Take deep breaths.

6) Share an anecdote in relation to work that made you feel useful, hopeful, appreciated, acknowledged or grateful. If no one has anything to share for item #6, move to item #7.

7) Share something you did for self-care that was helpful.

8) Conclude with offering a word or phrase for how you feel right now after this team meeting.

This handout is available along with other W2W materials at: https://www.migrantclinician.org/toolsource/resource/witnessing-resources.html

Concrete Ways to Address Vaccine Hesitancy

Claire Hutkins Seda, Senior Writer and Editor, Migrant Clinicians Network

We reached out to members of MCN staff and MCN's Board of Directors to ask what hesitancies their patients are expressing, and how they as clinicians are responding to those hesitancies. Here are their responses:

Laszlo Madaras, MD, MPH, Chief Medical Officer of Migrant Clinicians Network and hospitalist at WellSpan Summit:

In our area of central Pennsylvania, many people have seen their family and friends hospitalized due to COVID over the past year. Many have chosen to get vaccinated as soon as the vaccines were made available, for protection of both themselves and their families. They have been very happy with their decision. For those who have been hesitant, some just didn't want to be the first, and as they see their neighbors vaccinated and remaining healthy, they gradually agree to get their shot for themselves and their loved ones.

For those who never plan to accept COVID vaccination for themselves, there are many reasons. Some feel a lot of suspicions still about the vaccine, most often that it was developed too quickly to be safe. Also, there is a fear not based in fact that this vaccination will forever change your DNA and make it difficult to have children. There is an underlying assumption of maleficence combined with a fear of the unknown which, when combined with known historical facts about the mistreatment of marginalized Americans, makes for understandable hesitancy. While I disagree with this view of the COVID vaccine, I try to treat the people who hold these views with respect, compassion, and (if they are agreeable) with dialogue.

My counterargument has been that half a million Americans have died of COVID-19 without the vaccine in 2020 alone, and the arrival of the vaccine and an effective vaccination program has significantly decreased the number of people needing hospitalization on a ventilator and dying. I work as a hospital doctor and can see this improvement firsthand.

The speed of vaccine development is a tribute to the progress of biochemistry and genetic science over the past two decades since the Human Genome Project, and should be applauded. There have been many years of research on an effective vaccine for the coronavirus family. Nevertheless, I acknowledge that the post-vaccination results have only been monitored for a few months (and only now do we even have 18 months of data on this new virus itself), so we cannot be too cavalier about knowing the full long-term benefits and side effects until many more months of observation have passed. But, that again is part of the scientific process, which had to adapt to a rapidly emerging virus.

And I tell patients that I myself have taken two doses of the first available vaccine when it was offered so I not only talk the talk, but I also walk the walk.

Vicki Thuesen, APRN, WHNP, FNP, Clinical Director of Agricultural Worker Health & Services at Montana Migrant and Seasonal Farmworkers Council:

The common hesitancies we are hearing are the worry that the government put a chip in the vaccine that will track immigrants and cause them to be deported; that the vaccine can alter genes and cause infertility; that you don't need the vaccine if you have already had COVID; that you only need one dose of Pfizer or Moderna if you already had the virus; that the virus isn't safe because it was developed too quickly.

We have tried to debunk these myths or misinformation in several ways. First, one of our board members and an employee made posters and pamphlets in English and Spanish addressing each of the above concerns. We posted these in our clinics and on our website. **We identified people in each of our communities who would be advocates for vaccinating. We found people who would be advocates in churches, food banks, etc.** We have found that migrant workers who have been coming to our clinics for many years are somewhat hesitant. H2A workers who are coming into the area seem to be asking right away where they can get the vaccine.

Robert Shelly, MD, FAAP, Internal Medicine and Pediatrics, Sodus Community Health:

My impression is that we are not seeing the degree of vaccine hesitancy in this group that has been reported in the media. In my experience, immigrant agricultural workers typically view vaccines (and injectable treatments in general) favorably. Our outreach teams are also doing a lot of education and have decades of established relationships in the community. Regarding my approach with patients, I emphasize… [that] widespread vaccination offers our best chance of moving beyond this crisis. But I think that relationships and personal trust matter more than science when it comes to encouraging people to be vaccinated. My approach generally includes:

- Empathy with folks that it can be scary to think of receiving a new vaccine that many people are afraid of, that receiving the vaccine is an individual choice, and that I won't judge them for their decision.
- That I personally believe in the benefits of the vaccine and received it myself.

Having a relationship over time with people is very helpful, as quite a few have told me that they were waiting to decide about the vaccine until talking to me. Last week, an immigrant patient started his visit telling the staff he wouldn't get the vaccine because he heard that it 'was responsible for the genocide that happened in New York City,' but left the visit expressing willingness to get the vaccine.

Gayle Thomas, MD, Medical Director of the North Carolina Farmworker Health Program:

The most common [hesitancy] is, 'it is too new, [and] we don't have enough experience with it yet.' My response: 'we started working on vaccines against viruses like this one about ten years ago when SARS and MERS were spreading. **We have given this one to millions of Americans now**, so we do have experience with it.'

Eva Galvez, MD, Family Physician with Virginia Garcia Memorial Health Center, Oregon:

There are a variety of concerns that my patients express, but what I am hearing most is that they are worried about vaccine safety and the potential long- and short-term health risks.

My response is to first validate their concerns and to reassure them that it is normal to have these concerns. I tell them that an important step in deciding whether or not to get the vaccine is **to ensure that all of their questions are answered and that they are obtaining their information from a trusted source.**

From there, I do my best to provide them with basic information regarding the vaccine development and potential side effects. For **many, I find that just hearing that it is safe from someone that they trust, for instance, their doctor can be quite powerful** and might be enough to sway them in the direction of getting the vaccine.

Carmen M. Velez Vega, PhD, MSW, Community Health Capacity Building Program at the Puerto Rico Public Health Trust:

I have heard people say they don't trust the vaccine because of the short time it took to be approved. I have also heard they believe the vaccine introduces harmful substances in the body. Some people refer to memes and social media messages that warn against the vaccination and see it as a form of killing people off. Mostly misinformation spread through social media. Education is key. **Creating messages that speak to a diversity of audiences. Using spokespersons that look like them, people they can relate to. Having community doctors, nurses, and other professionals present the message.** At the Puerto Rico Public Health Trust, we brought together a scientist and a social media celebrity to send a message together.

New Resources to Support COVID-19 Vaccine Provision for Agricultural Workers and other Immigrant and Migrant Essential Workers

Claire Hutkins Seda, Senior Writer and Editor, Migrant Clinicians Network

In some parts of the country, essential workers, many of whom are immigrant and migrant agricultural workers who have labored tirelessly to keep food on our tables throughout the pandemic, still lack reliable and easy access the COVID-19 vaccine. For farmworkers and other food workers, this is in part due to the many barriers they face to access any health care, even before the pandemic. Very rural locations, limited modes of transportation, limited time off from work, poor access to health information including local resources, limited technology access, and language and cultural differences each may prevent many essential workers from successfully finding information on local vaccine sites, securing an appointment, and being able to attend the appointment. In addition to these barriers, just like the rest of the US population, many workers have concerns over the speed of the development of the vaccines, and may have encountered health misinformation that sows doubt on the safety of the vaccines.

Yet, agricultural workers may be the most important subgroup of the overall population to receive the vaccine. A paper currently in pre-print that evaluated California records on deaths of Californians aged 18 to 65 from COVID-19 between March and October 2020 found that Latinx food/agriculture workers had the highest rate of increase in mortality among all ethnicities and occupations, with a 59 percent increase in mortality.[1] Latinx Californians overall experienced a 36 percent increase. Caucasian Californians' excess mortality increased six percent. Caucasian food/agricultural workers saw a 16 percent increase.

"This increase in excess mortality confirms the heightened occupational risk of COVID-19 infections that food and farm workers face, while simultaneously exposing the racial and ethnic disparities in infection," said Amy K. Liebman, Migrant Clinicians Network's Director of Environmental and Occupational Health. "It also underscores the importance of ensuring that this worker population, deemed as essential, gets prioritized for vaccinations both from a policy perspective and on the ground. We need to do all it takes so that vaccines get to workers and we don't wait for workers to get to vaccines."

Indeed, many community health centers and other sites of health care provision are increasing outreach to food and farm workers, and ensuring that those efforts are culturally sensitive. To support clinicians in this work, Migrant Clinicians Network has developed numerous resources and tools useful in preparation for COVID-19 vaccine provision. This packet of resources, developed with support from the Health Resources and Services Administration, is available on the MCN website at: https://bit.ly/3o2MKv8.

#YoMeLaPuse

MCN's #YoMeLaPuse campaign offers a short video in Spanish and accompanying five downloadable flyers that show five people of various ages who are proud to get the vaccination. A sixth poster is a template for communities to customize the poster with local community leaders and members, to emphasize the local community's support of vaccination.

- Video in Spanish: https://bit.ly/38FM60k
- Five posters in Spanish, and a sixth template poster for users to create their own poster: https://bit.ly/38IdwCI

FAQ: The COVID-19 Vaccine and Migrant, Immigrant, and Food and Farm Worker Patients *https://bit.ly/3gcj8K2*

Our list of frequently asked questions covers common questions that MCN fields from clinicians in our network, specifically for essential worker communities. The list is regularly updated as new questions arise. Available in English and Spanish.

Las vacunas mRNA contra el COVID-19 con Dra. Eva Gálvez (The mRNA Vaccines against COVID-19, with Dr. Eva Galvez) *https://bit.ly/3cmzCeP*

For a more in-depth look at the mRNA vaccines, how they work, their side effects, and more, Dr. Galvez recorded this 23-minute informational video, in Spanish.

Additional materials are available from MCN, on the MCN website:

Checklists: Preparing for an In-Person Event

MCN's latest checklists assist outreach teams hosting in-person events when virtual gatherings are just not possible.

In English: COVID-19 Vaccines: Health Department and Vaccine Clinic Considerations to Reach Migrant and Immigrant Workers https://bit.ly/3tsOOhy

In Spanish: Vacunas COVID-19: Consideraciones para departamentos de salud y clínicas de vacunas para llegar a los trabajadores migrantes e inmigrantes https://bit.ly/3vzQAPD

In English: Safely Conducting "Touchless" Outreach Events During COVID-19 to Bring Services to Refugee, Immigrant, and Migrant Populations https://bit.ly/3cGbcxg

In Spanish: Realizando eventos "sin contacto" con seguridad durante COVID-19 para llevar servicios a poblaciones de refugiados, inmigrantes y migrantes https://bit.ly/30VdZwS

"Vaccination is…" Campaign *https://bit.ly/3vWRfu8*

Inspiring posters and customizable social media-ready messages in English, Spanish, and Haitian Creole deliver simple, digestible messages about the vaccine.

What to Expect When Getting the COVID-19 Vaccine *https://bit.ly/3cm0k7r*

This colorful flyer lists common side effects; notes that the vaccine is free including immigrants; pushes for the need for continued diligence in mask wearing, maintaining distance, and washing hands; and encourages people to get a vaccine even if previously infected. Developed by East Coast Migrant Head Start and adapted by MCN in partnership with the Maryland Lower Shore Vulnerable Population Task Force, the original flyers – available in

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reach services including food assistance if they identify a need during a clinical encounter.

In March 2020, as the scope of the pandemic became apparent, Virginia Garcia and the Oregon Food Bank realized they could not hold in-person free food markets and scrambled to find another way to get food to families in need. At some sites, the partners switched to holding drive-through markets with pre-packaged boxes of food. At other sites, they worked with other local organizations such as Centro Cultural in Cornelius to have outreach workers deliver food boxes to families. Like the free food market, the food boxes are customized with culturally appropriate food items. Kendra Powell, LCSW, Primary Care Social Worker Supervisor and Roxanna Pascual, Regional Operations Manager from Virginia Garcia say that the Oregon Food Bank has been very open to changing the type of food they provide based on cultural and dietary preferences.

At their five sites, Virginia Garcia outreach workers have been particularly diligent about getting food boxes to patients who have tested COVID-19 positive and are required to isolate at home. Powell and Pascual estimate that in the Yamhill County area alone as of March 2021, Virginia Garcia is delivering 50-70 food boxes a week. They say that this represents a significant increase over a year ago. The increased need is also evidenced by the fact that in past years families would often only need one food box a month. Once COVID-19 hit, many of the same families needed a food box every week. Powell and Pascual say that the pandemic exploded the need for social support as families lost work or were forced to isolate or quarantine.

Where do we go from here?

Local support services will continue to be a critical component to address food insecurity among agricultural workers, in part because they better understand the cultural and dietary needs of their clients. They are also better at finding community gatekeepers to increase trust in the services provided. Additionally, local organizations understand how to reach hard-to-find people and communities. At the same time, it is critical to continue to advocate for state and federal policies that address the root causes of hunger in all low-income populations. Ensuring a living wage for agricultural workers would go a long way towards addressing food insecurity, but there are other issues to consider including transportation and access to healthy food. The COVID-19 pandemic has exposed fissures in our social fabric and shone a light on pre-existing inequities. The pandemic has also shown how essential agricultural workers are to the systems that allows us all to have access to food. In this moment, it is critical to advocate for a world in which agricultural workers and their families have consistent access to enough food to support active and healthy lives.

Virginia Garcia offers a free food market through a collaboration with the Oregon Food Bank.

Photo courtesy of Virginia Garcia.

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5 United States Department of Labor. Findings from the National Agricultural Workers Survey, 2013-14. Research Report No. 12 (published 2016) at iii, 37-38. The survey asked farmworkers to report their income from the year before. We therefore compare the NAWS results to data in other surveys from 2012. Available at: https://www.dol.gov/agencies/eta/national-agricultural-workers-survey/research

6 Feeding America. The impact of the coronavirus on food insecurity in 2020 and 2021. March 2021. Available at: https://www.feedingamerica.org/sites/default/files/2021-03/National%20Projections%20Brief_3.9.2021_0.pdf

7 Farmworker Justice, Hunger amidst plenty: Food assistance in farmworker communities. Blog post. Available at: www.farmworkerjustice.org/food-assistance-in-farmworker-communities

New Resources continued from page 6

English, Spanish, and Haitian Creole – were curated for Maryland, Delaware, and Virginia, but downloadable templates allow users to customize the flyers for their state.

Anuncio: La Vacuna del COVID-19: Dra. Eva Galvez, una doctora sirviendo a las comunidades migrantes (COVID-19 Vaccine: Dr. Eva Galvez, A Doctor Serving Migrant Communities) *https://bit.ly/2OLgLCg*
Dr. Eva Galvez, the chair of MCN's Board of Directors, recorded a short video in Spanish on vaccination and fears around it, which could be useful to play in clinics or during community events.

Vaccine Calendar: Los grandes también se vacunan (Adults Also Get Vaccinated) *https://bit.ly/38N7TTF*
MCN's colorful vaccine calendar has been newly updated to include the COVID-19 vaccines. This calendar, presented as a wheel and surrounded by an engaging comic, gives low-literacy information on vaccines and some information on why adults need immunizations, too. Available for download on MCN's page in high resolution for poster-size printing.

You can find more multilingual resources from MCN and other organizations on our COVID-19 page, which is available in English and Spanish: https://www.migrantclinician.org/COVID-19-pandemic. You can also learn more about our work to support clinicians and their patients by subscribing to our blog: https://www.migrantclinician.org/blog.

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calendar

June 3, 11am PT/1pm CT/2pm ET
Ag Worker Health 102:
Supporting Agricultural Worker Health
Virtual Session
https://www.migrantclinician.org/trainings.html

June 15-July 1
16th Summer Institute on Migration and Global Health
Virtual only
https://hia.berkeley.edu/summer-institute-on-migration-health/

July 6-10
The Migration Conference 2021
Virtual only
https://www.migrationconference.net/

August 22-24
Community Health Institute and Expo
In-person in Orlando, FL, with a virtual option
https://www.nachc.org/conferences/chi/

September 9-11
North American Refugee Health Conference
Virtual only
https://www.northamericanrefugeehealth.com/