COVID-19 IMPACT ON AGRICULTURAL WORKERS

Updated March 2022

Agricultural worker populations are disproportionately impacted by COVID-19 due to factors including lack of personal protective equipment (PPE), poor housing and working conditions, structural racism, discrimination, and barriers to health care. This fact sheet is updated quarterly, focused on peer-reviewed literature, to bring the most current information about the pandemic's impact on agricultural workers.

COVID-19 PREVALENCE AMONG AGRICULTURAL WORKERS AND RURAL COMMUNITIES

- As of March 16, 2022, there have been 1 million agricultural worker COVID-19 cases confirmed. This figure likely underestimates the number greatly since it excludes contracted and temporary labor.[1]
- As of March 15, 2022, over 11.4 million cases of COVID-19 and 170,678 deaths from COVID-19 have been reported in rural counties. This is about 14.6% of all U.S. cases and 18% of U.S. deaths reported at this time. The current prevalent case rate in rural counties is 2,480 cases per 10,000 residents and the current death rate is 37.04 per 10,000 residents. The prevalent case rate is now higher in rural counties than urban counties.[2]

DISPROPORTIONAL IMPACT

- Research by the Centers for Disease Control and Prevention (CDC) found that Hispanic or Latino workers employed in food production or agriculture have a substantially higher prevalence of COVID-19 compared to non-Hispanic workers in those industries. Among the 31 states that reported data, only 37% of workers in those industries were Hispanic or Latino but they represented 73% of laboratory-confirmed COVID-19 cases in food processing and agriculture industries.[3]
- Hispanics are disproportionately affected by COVID-19, experiencing significantly higher rates in positive cases and increased mortality from the virus than other ethnicities.[4,5]
- In a study comparing positivity rates from June 2020 to November 2020, agricultural workers were more likely to test positive than the general population.[6]
- Underlying health conditions can increase the severity of the impact of the COVID-19 virus.[7] For example, diabetes is a risk factor for acute respiratory distress syndrome (ARDS) and mortality in patients hospitalized with COVID-19.[3,5] Research suggests that agricultural workers have high rates of diabetes and obesity, with factors such as pesticide exposure increasing the odds of diabetes.[8,9,10]
- Social determinants of health, such as racism and discrimination, can lead to underlying health factors impacting the severity of COVID-19 cases.[11] Agricultural workers report discrimination from employers based on their country of birth, legal status, and ability to speak English, that directly impacts their access to healthcare when injured.[12] The anti-immigrant narrative can be a factor of discrimination in the United States.[12,13]
- Indigenous language speaking agricultural workers lack access to translators, interpreters, or other resources within the U.S. health care system that could negatively impact their ability to access educational resources and care for COVID-19 related illness and prevention.[14] This includes lack of translation of both testing results and medical recommendations.[15]

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OCCUPATIONAL RISKS AND WORKING CONDITIONS ON U.S. FARMS

- Latinx/Hispanic agricultural workers in California experience higher than usual occupational stress due to the pandemic. In a study of 199 workers in Imperial County, approximately 40% reported statistically significant stress levels. Foreign-born and elder respondents were more likely to experience this elevated stress. This study also found that Spanish speakers conducting COVID-19 outreach might have been effective for those workers with reported stress from language inequity.[16]
- Due to working conditions, agricultural workers are not able to keep a safe physical distance to prevent the spread of the COVID-19 virus. They work close to each other while harvesting and packing, and often ride together to and from work in buses or vans, increasing the risk for spread.[17]
- Agricultural workers have been reported being fearful of losing their job after taking time off to access health services because employers have been reported to threaten deportation or other retaliation to those who do take off work.[18,19]
- In Central Florida in June 2021, from a study of 92 agricultural workers, 75% reported losing work hours due to the pandemic or lost work completely due to being let go by their employer.[17]
- COVID-19 workplace safety precautions vary based on the employer. For example, out of the 92 agricultural workers in Florida, 87% of workers reported employer-enforced physical distancing, 34% reported mask-wearing, and 12% reported regular temperature checks.[17] See Figure 1 below.

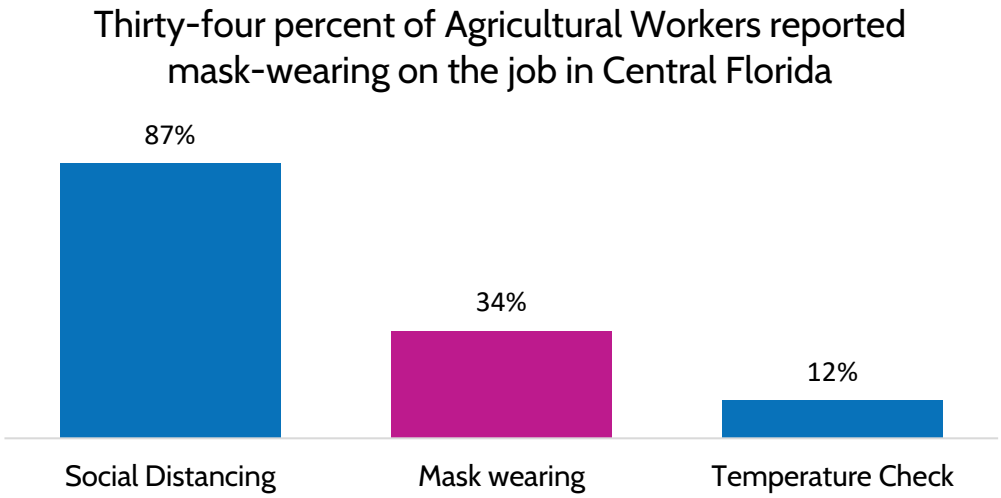


Figure 1: Source: COVID-19 and Agricultural Workers: A Descriptive Study (2021)

- Instead of masks, agricultural workers tend to wear bandanas or scarves to mask their face because their employers don't usually provide appropriate PPE.[20,21] Studies indicate that bandanas and neck gaiters are less efficient in reducing the spread of respiratory droplets.[22]

HOUSING CONDITIONS AND RISK

- Overcrowded and substandard housing conditions are a major concern for the potential of COVID-19 to spread through agricultural worker communities.[23,24]
- A single building may house several dozen workers or more, who often sleep in dormitory-style quarters, making quarantining or physical distancing efforts difficult if not impossible. Limited access to restrooms and sinks, at home and in the field, may complicate hygiene prevention efforts.[25]
- Several states and counties provide funding for emergency quarantine housing for agricultural workers suffering from COVID-19. Other state and counties added funds to pay for lost wages or assistance with bills for agricultural workers affected by COVID-19 in 2020.[26,27,28]

ACCESS TO CARE

- Data from Community Health Worker (CHW) interviews suggest agricultural worker health could be improved through key strategies including 1) improved professional development for CHWs, 2) identification of preferred methods of health education delivery, and 3) technology enhancements including internet access in rural areas. CHWs reported that health education was more successful when they included open ended questions, interactive and participatory activities, and non-verbal aides in their delivery.[29]
- Health care services can be inaccessible due to lack of health insurance, sick leave policy, or transportation.[17,28,29] Services that are available may be culturally, medically, or linguistically inappropriate.[17,30,31,32,33] Negative experiences with health care, including medical racism, and other significant barriers within the health care system has created a general mistrust that agricultural workers have for the U.S. health care system.[17,29,31]
- Extremely low annual incomes and a widespread lack of access to health insurance may limit health care-seeking behaviors among agricultural workers, even if they are experiencing symptoms of an illness.[31,34]

PROMISING PRACTICES

- Isolating agricultural workers helped mitigate an outbreak in Iowa. In summer of 2021, nine workers tested positive for COVID-19, including many who were asymptomatic. COVID-19 positive workers were isolated for 10 days with meals and hygiene products provided. Proteus Inc., a Migrant Health Voucher Program, conducted check in calls to assess health status. The workers returned to work after isolation and no additional positive cases occurred during that harvest season.[35]
- Working and communicating with the employer was essential to identify positive cases among H-2A workers and to isolate workers to prevent future outbreaks. Using Coronavirus Aid, Relief and Economic Security (CARES) funding, Proteus Inc. safely transported 170 workers from Mexico to Iowa. Masks were mandatory during travel and workers received a PCR test at arrival. All workers with positive results were isolated for 10 days. Evaluation was provided through telehealth and treatment was prescribed and delivered by Proteus during this time. Close contacts of those positive who tested negative were isolated for 7 days, evaluated, and retested 7 days after the initial test. After retesting, those who tested negative were released to communal living and to start work.[36]
- In order to mitigate outbreaks, Proteus Inc, worked with employers to transport H-2A workers from Mexico to Iowa, with a model that kept workers in travel cohorts, tracked close contacts, and set up isolation procedures upon arrival. The model produced a 3.5% positivity rate compared to a 12.7% positivity rate in previous H-2A worker transportation on the same farm. During transportation workers were assigned a bus and a seat and required to wear masks. Workers received a PCR test upon arrival and those with a positive result were isolated for 10 days in employer-provided housing. Workers in isolation were medically evaluated via telehealth and were delivered medicine as needed. Close contact of workers that tested positive were also isolated, tested regularly, and released seven days post exposure if they tested negative.

COVID-19 VACCINATION

- In 2020, health centers provided primary care to almost 1 million agricultural workers and their families.[37] As of November 2021, almost 212,300 COVID-19 vaccine doses have been administered to agricultural workers through Migrant Health Centers.[38]
- Health Resources and Services Administration (HRSA) conducts a bi-weekly survey of health centers. The data represent a two-week reporting period. Data available from February 25, 2022, reports 1,105 (80% of total) health centers responded. Out of 56,223 patients initiating vaccination during those two weeks, 46.52% self-identified as Hispanic or Latino (not including those reporting “one or more race”). Out of 110,591 patients who received additional vaccinations after completing the series, 44.67% self-identified as Hispanic or Latino (not including those who have reported “one or more race”).[39] Thirty-two of 1,105 health centers reported staffing challenges to administer the vaccine and 32%of health centers reported vaccine confidence challenges in the February 25th biweekly report. Thirty-seven percent reported no challenges with administering vaccinations.[39]

- As part of the Health Center COVID-19 Vaccine Program, over 19.8 million vaccinations have been administered from February 26, 2021 to March 16, 2022. Approximately 69% of those patients self-identified as a racial and/or ethnic minority (including Hispanic/Latino).[40]
- Research suggests concerns about side effects and mistrust in the vaccine are the top two reasons leading to vaccine hesitancy among agricultural workers.[17]
- In July 2021, 53% of agricultural workers in Central Florida reported receiving a COVID-19 vaccine.[17]
- In a study among rural and urban adults, a greater percentage of urban residents (46%) received their first dose of a COVID-19 vaccine than rural residents (39%).[41] See Figure 2 below.

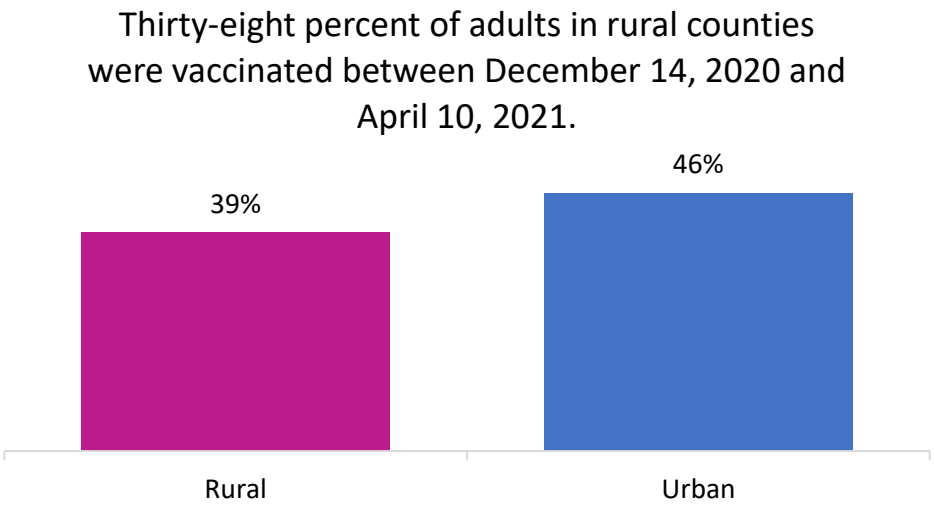
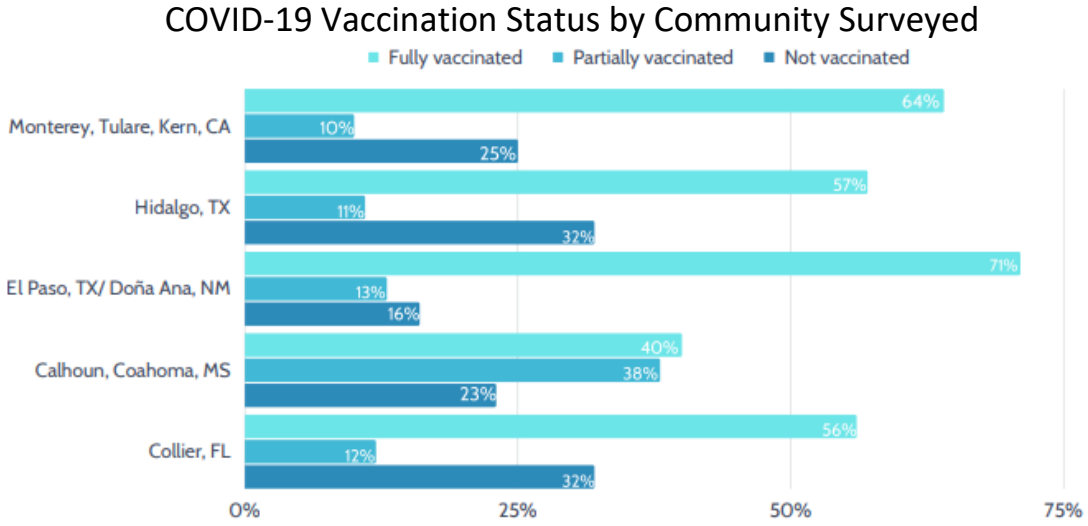


Figure 2: Source: CDC The Morbidity and Mortality Weekly Report

- In 2021, 1,094 surveys were conducted with agricultural workers in five communities to assess COVID-19 impact. COVID-19 vaccination coverage varied by community (see Figure 3), however the percentage of respondents that were fully vaccinated was lower than the county vaccination rate at the same time in four out of the five communities.[42]



**Fully vaccinated includes respondents who received one dose of the Janssen/Johnson and Johnson vaccine or two doses of any COVID-19 vaccine approved by the U.S. Food and Drug Administration or the World Health Organization. Partially vaccinated respondents include those who received one dose of a two-dose FDA- or WHO-approved vaccine, and those who received an unapproved vaccine. Not vaccinated respondents did not receive any COVID-19 vaccine.*

Figure 3: Farmworker Covid-19 Community Assessments Executive Summary

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