

## Sociodemographic Characteristics, Health, and Success at Obtaining Work among Latino Urban Day Laborers

Ronald W. Nelson, Jr., BA

Geri Schmotzer, RN, MSN, MPH, PhD

Barbara J. Burgel, RN, PhD, FAAN

Rachel Crothers, BA

Mary C. White, RN, MPH, PhD

**Abstract: Background.** The purpose of this study was to examine the health and social circumstances, knowledge of and access to health and social services, and success at getting work among urban day laborers. **Methods.** We conducted an interview survey of 217 men waiting for work at several sites in San Francisco. **Results.** Day laborers were generally unsuccessful at obtaining work and had less than optimal housing, but supported a number of family members. Over half reported fair or poor health, associated with longer time as a day laborer, poor English proficiency, and financially supporting three or more other people. Awareness of health and social services available to them was low. **Discussion.** The stress of seeking work daily, separation from family, inadequate housing and lack of health care puts this population at increased risk for disease conditions associated with poor physical and mental health.

**Key words:** Latino health, immigrants, day laborers, urban health.

Urban day laborers search for temporary employment on street corners, in front of home improvement stores, paint supply stores, city-sponsored centers, and moving facilities. Given the temporary nature of their work, day laborers tend to earn less, to have few worker rights, and to suffer increased economic vulnerability than people employed in regular jobs.<sup>1,2</sup> Occupational health risks have been documented in the recent literature, involving high-risk job activities and little access to safety equipment or controls.<sup>3,4</sup> Latino immigrants constitute a majority of the day labor work force and many are undocumented,<sup>3</sup> complicating their work status and access to social

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*At the time of this work, RONALD W. NELSON, JR., BARBARA J. BURGEL, RACHEL CROTHERS, and MARY C. WHITE were affiliated with the University of California, San Francisco School of Nursing, Department of Community Health Systems. Currently, Mr. Nelson is with the Tulane University School of Medicine, and Ms. Crothers is with the University of California, Davis School of Medicine. GERI SCHMOTZER is affiliated with the New Mexico State University School of Nursing in Las Cruces. Please address correspondence to Mary C. White, MPH, PhD, Professor Emeritus, Community Health Systems, University of California, San Francisco School of Nursing, 2 Koret Way, Box 0608, N511R, San Francisco, CA 94143-0608; (415) 476-5213; Mary.white@nursing.ucsf.edu.*

and health programs. Separated from their families and experiencing economic and cultural stresses, Latino day laborers enter a shadow labor force, sometimes called the *underground economy*. Regardless of their documentation status, they are viewed by many business leaders as critical to the local economy but by many members of the general public with hostility and fear that they are taking jobs from U.S.-born workers.<sup>5</sup>

Some research has been conducted on the general and occupational health of Latino urban day laborers, barriers to care, and cultural alternatives in seeking health care.<sup>6</sup> We proposed to look in depth at the social conditions of this population, their understanding of the health and social system, and their success in obtaining work. Because of the stresses involved in both immigration and the search for unstructured, casual work in a new city, we hypothesized that time would be a key variable: those who had been in the city longer would have more success and would be more knowledgeable about health and social services available to them. Our research questions were the following: 1) What are the sociodemographic characteristics (including living and family situations) of Latino urban day laborers? 2) What is their health status, including knowledge of and access to health and social services? 3) Are they successful in getting work, and what are the social and health-related characteristics associated with their success?

## Methods

**Design, setting and sample.** This descriptive, cross-sectional study was conducted from April to August in 2009 in San Francisco. In collaboration with community partners, the primary places where people gather to look for day work in the city were identified. Based on estimates of the total number of individuals waiting for work at all the sites, study personnel planned to approach a proportional number of workers at each site. In all, data were collected by interviews of 217 Hispanic day laborers selected at five general street corner areas and a work center. Men, age 18 and older, who self-identified as Latino and were looking for work as a day laborer constituted the sample.

**Study procedures.** Study personnel identified groups of men at a site and approached one from each group during a given interview day; if there was a line, study personnel systematically approached people at the start, middle, and end of the line (or every second or third person in line). The interviewer approached the worker on foot and asked if he was looking for work for the day, and then determined his interest in being interviewed on personal, health, and health care questions. After providing informed consent, interviews were conducted by mutual agreement in a location that was private, such as a nearby park bench or location at a distance from other people. Interviews were conducted in the participant's preferred language and at its completion, study personnel gave the participant an information packet which included contact information for local free clinics, with their locations noted on a map of San Francisco. Participants were provided information about enrolling in Healthy San Francisco, San Francisco's landmark program begun in 2007 to provide the uninsured with access to health care services without concern for documentation status.<sup>7</sup> Participants could end the interview at any time if they thought work was available for them, and they received \$25 in compensation for their time in completing the one-hour interview.

**Data collection and measures.** The structured interview in English or Spanish

included questions on general sociodemographic characteristics (age, years of education, marital status, country of birth, year of immigration, and time since they began looking for work in San Francisco as a day laborer). Other sociodemographic, health and job-related data were gathered by the questions in Box 1.

**Analysis.** As we hypothesized that people in the San Francisco urban day labor pool longer would likely differ from those who had recently arrived, our descriptive analyses began by examining demographic and social characteristics by the time they had spent as day laborers in San Francisco. While we present here many of the findings by the

**Box 1.**

**QUESTIONS ELICITING SOCIODEMOGRAPHIC, HEALTH, AND JOB-RELATED INFORMATION**

Data	Survey Questions, Data Management and Rationale
English Proficiency	<p>How well would you say you speak English? (responses ranging from very well to not at all) and limited English proficiency was dichotomized as those who spoke English not well or not at all compared to those who spoke English well or very well.<sup>8</sup></p>
Housing	<p>What language do you speak at home?</p> <p>In the last month, where have you been living? (responses: own apartment, house or room; shared room; house or apartment of friends or family; hotel; board or care facility; homeless shelter; hospital; alcohol or drug treatment program; on the streets, park, abandoned building, car/truck, camping outside; or other, specified by the participant)</p> <p>In the last month, did you spend any night on the street or in a shelter? Those saying yes or saying they lived in a homeless shelter, on the streets, park, abandoned building, car or truck, or camping outside were categorized as having unstable housing.</p>
Financial Support	<p>Other questions included whether or not they shared a room, shared a bed with someone who was not their partner or spouse, and had a place to store their things.</p> <p>Financial support they provided for themselves and for others, in San Francisco, in other parts of the U.S. and outside the U.S.</p> <p>Who else they supported, their relationship to the participant, and whether there were others who helped support them or the family.</p>

*(Continued on p. 800)*

**Box 1. (continued)**

Health Status	<p>Self-ranked health (responses: excellent, very good, good, fair or poor) as asked in the National Health Interview Survey (NHIS).<sup>9</sup></p> <p>Substance use questions on current smoking; days and number of alcoholic drinks per day in the last month and how many times they had <math>\geq 5</math> drinks on one occasion; use of drugs not prescribed to them in the past year, including street drugs, and if yes, what drugs.</p> <p>Whether they get enough food to eat.</p> <p>Has a doctor or nurse ever told you that you have any of the following conditions (asthma, lung disease, diabetes, high blood pressure, heart disease, arthritis, or depression) as used in the NHIS.<sup>9</sup></p>
Knowledge and Access to Health Care	<p>What health services are they aware of in San Francisco; awareness of social services in San Francisco (and asked to list).</p> <p>Ever seen a doctor or a nurse?</p> <p>Is there a place that they usually go to when sick or needing advice about health?</p> <p>Do they have insurance (with interviewers providing examples to explain the different types). Those who said they had no health insurance were asked for a main reason why (responses: changed employer/lost job; employer did not offer; not eligible due to working status; not eligible because of health or other problems; not eligible because of citizenship/immigration status; couldn't afford/too expensive; family situation changed; lost public program coverage; don't believe in insurance; no need because they are healthy; denied coverage with reason not specified; didn't like/want insurance; or other).</p>
Success at Obtaining Work	<p>Did they work during a season (Fall, Winter, Spring, Summer) because the type of work day laborers may seek, and thus their success, differs by seasonal changes. Success at obtaining work was generated by responses to questions about how many days they looked for work and how many days they got work.</p> <p>When they started to wait for work, when they got picked up, and when they stopped work for a usual week. Hours waiting and hours worked were generated from these times.</p>

median split, we also analyzed data using months in San Francisco as a continuous variable, and did not find results that differed from those conducted using the dichotomy.

To answer questions about health status and access to care, we examined demographic and social characteristics, behavioral characteristics, and access to care. Those significantly associated with health status in bivariate analysis, by chi-squared or t test, were entered into regression analyses. We analyzed factors that were associated with participants self-reporting as having fair or poor health, compared with those reporting good, very good, or excellent health. We generated adjusted odds ratios (AOR) and 95% confidence intervals (CI) to show the independent effects of factors associated with poorer self-reported health.

For success at obtaining work, we summed days looking for work, hours waiting, and hours worked to generate measures of effort among those who tried for work by each season. We computed the number of days they obtained work divided by the number they tried to get work as a percent success, by season. We then examined sociodemographic characteristics (age, time looking for work in San Francisco, years of education, English proficiency, marital status, housing stability, and number of others supported), and health and access characteristics (perceived health status, presence of a chronic condition, awareness of health services, and having a place for health care) for associations with success, by Pearson's correlation and t tests; those significant in bivariate analyses were included in a linear regression.

For all analyses, alpha was set at .10 for inclusion in regression analyses, and set at .05 for determination of final statistical significance. The study was approved by the Committee on Human Research at the University of California, San Francisco.

## Results

**Sociodemographic characteristics.** The sample included 217 men with an average age of 37 (range 18–74), who had been in San Francisco as a day laborer from one month to 27 years (mean 55 months, standard deviation [sd] 55.3). Because workers moved among street corners and the work center, we were not able to distinguish characteristics of the sample by interview site. All self-identified as Latino, and were born in the following countries: Mexico (55%); Guatemala (23%); El Salvador (10%); Honduras (8%); Nicaragua (2%); the remaining three from Costa Rica, Bolivia, or Peru (3%). General sociodemographic data are presented in Table 1 by time in San Francisco, dichotomized at the median time, 36 months. All interviews were conducted in Spanish, and participants primarily were Spanish speakers: 89% reported that they spoke Spanish at home, and 12% said they did not speak English at all. As might be expected, those who were in San Francisco three years or less were over twice as likely as those here longer to have limited English proficiency (OR 2.4, 95% CI 1.0–5.6,  $p = .042$ ).

Description of the sample related to housing is also presented in Table 1. Just under half (46%,  $n = 99$ ) had unstable housing when any homelessness in the past month was included in the definition. Of those who had stable housing, 70% said they shared a room with one to eight others (mean 2.5, median 2 others); 12% said they had to share a bed with others who were not their spouse or partner; and 7% said they did not have their own space where they could keep their things. Those who were day laborers for

**Table 1.**  
**CHARACTERISTICS OF URBAN DAY LABORERS BY YEARS**  
**LOOKING FOR WORK IN SAN FRANCISCO**

Characteristic	≤3 years N=116 N (%) <sup>a</sup>	>3 years N=101 N (%) <sup>a</sup>	Total N=217 N (%) <sup>a</sup>	p value
Mean Age (std. dev.)	33.6 (9.6)	40.4 (10.1)	36.6 (10.4)	.000
Median	33	40	37	
Mean years education (std. dev.)	8.4 (3.2)	9.0 (3.8)	8.7 (3.5)	.213
Median	8	9	8	
Marital status				.150
Married or living with partner	49 (42%)	40 (40%)	89 (41%)	
Divorced or separated	14 (12%)	22 (22%)	36 (17%)	
Never married	53 (46%)	39 (39%)	92 (42%)	
Speak English				.003
Very well	2 (2%)	2 (2%)	4 (2%)	
Well	7 (6%)	15 (15%)	22 (10%)	
Not well	85 (74%)	80 (79%)	165 (76%)	
Not at all	21 (18%)	4 (4%)	25 (12%)	
Housing in the past month				.194
House or apartment	80 (69%)	66 (65%)	146 (67%)	
Homeless shelter	27 (23%)	17 (39%)	44 (20%)	
On the streets	7 (6%)	13 (13%)	20 (9%)	
Board or care facility	2 (2%)	4 (4%)	6 (3%)	
Alcohol/drug treatment facility	0 (0%)	1 (1%)	1 (1%)	
Number of others supported in own home in U.S.				.370
None	63 (54%)	63 (62%)	126 (58%)	
One other	20 (17%)	19 (19%)	39 (18%)	
Two others	11 (9%)	8 (8%)	19 (9%)	
Three or more others	22 (19%)	11 (11%)	33 (15%)	
Number of others supported in other places in the U.S.				.072
None	108 (93%)	88 (87%)	196 (90%)	
One other	1 (1%)	5 (5%)	6 (3%)	
Two others	2 (2%)	6 (6%)	8 (4%)	
Three or more others	5 (4%)	2 (2%)	7 (3%)	
Number of others supported outside the U.S.				.109
None	19 (16%)	30 (30%)	49 (23%)	
One other	11 (10%)	9 (9%)	20 (9%)	
Two others	27 (23%)	23 (23%)	50 (23%)	
Three or more others	59 (51%)	39 (39%)	98 (45%)	

<sup>a</sup>Number and percent of each group unless otherwise specified; numbers do not add to total sample size if not answered, and percents may not add to 100 because of rounding.

three years or less in San Francisco were 2.6 times as likely as those who were in San Francisco longer than three years to share a room with others (95% CI 1.2–5.9,  $p = .019$ ). Of those in spousal relationships (marriage or its equivalent), 78% reported that their spouse was not living in the household.

People supported by the participants were categorized in terms of whether the dependent lived with the participant, lived in another place in the U.S., or lived outside the U.S. While over half ( $n = 126$ , 58%) reported that they did not support anyone else but themselves in San Francisco, over three quarters ( $n = 168$ , 77%) reported that they supported one or more people outside the U.S. Only 31 participants (14%) reported that they did not support anyone but themselves. Participants in San Francisco three years or less supported on average more people (4.4) than did participants in San Francisco longer than three years (3.4) ( $p = .051$ ). Of those who supported at least one other person, 63% ( $n = 117$ ) said they were the sole provider of financial support to the family.

**Health status, and knowledge of and access to care.** Over half of the participants (54%,  $n = 118$ ) self-reported their health status as fair or poor (Table 2). Those in San Francisco three years or less were nearly twice as likely as those in the city more than three years to report good, very good, or excellent health (OR 1.8, 95% CI 1.1–3.2,  $p = .027$ ). Those in San Francisco three years or less were more likely to be smokers (OR 2.2, 95% CI 1.1–4.3,  $p = .023$ ). In contrast, those who were in San Francisco longer than three years consumed more alcohol: had more days drinking per month ( $p = .022$ ); consumed more drinks on an average day ( $p = .046$ ); and had more days on which five or more drinks were consumed ( $p = .040$ ). Those who were in San Francisco three years or less were less likely as those here longer than three years to have used street drugs or medications not prescribed for them, although the finding was not statistically significant. Of the 16% ( $n = 35$ ) of participants who indicated that in the past year they had taken drugs (either street drugs or medications not prescribed for them) the majority ( $n = 26$ , 74%) reported marijuana, and four reported polysubstance use including cocaine.

Knowledge of and access to health care was better among those who were in San Francisco longer: they were more likely to have ever seen a doctor or nurse, to have a place to go when sick, and to have health insurance, although only 14% overall reported having health insurance. Among the 86% who said they did not have health insurance, over half said they were not eligible because of citizenship status. Awareness of health and social services was also better in those who were in San Francisco longer, and overall nearly three quarters knew about health services, although only 15 participants were enrolled in Healthy San Francisco. Awareness of social services was limited, though, and even among those who had been in San Francisco longer than three years, over two thirds could not mention any social services except food or shelter services.

Bivariate analyses to examine factors associated with self-report of fair or poor health included sociodemographic and health-related variables. Because awareness of health services, having a regular place for care, and being told one had a chronic condition were highly correlated, only the presence of a chronic condition was entered into the logistic regression. Support for others was collapsed, because of the bivariate results, into those supporting three or more compared with those supporting fewer than three others. Table 3 shows the variables included, and logistic regression results for variables

**Table 2.****HEALTH AND ACCESS TO CARE AMONG URBAN DAY LABORERS BY TIME LOOKING FOR WORK**

	≤3 years N (%) <sup>a</sup>	>3 years N (%) <sup>a</sup>	Total N (%) <sup>a</sup>	p value
Health status				.057
Excellent	5 (4%)	6 (6%)	11 (5%)	
Very good	18 (15%)	6 (6%)	24 (11%)	
Good	38 (33%)	26 (26%)	64 (30%)	
Fair	53 (46%)	58 (57%)	111 (51%)	
Poor	2 (2%)	5 (5%)	7 (3%)	
Have enough to eat	41 (35%)	34 (34%)	75 (35%)	.795
Current smoker	32 (28%)	15 (15%)	47 (22%)	.023
Alcohol: Mean (std.dev.), Median <sup>b</sup>				
Days per month	2.4 (4.0), 1	4.1 (6.6), 1	3.2 (5.4), 1	.022
Drinks on an average day <sup>a</sup>	7.2 (4.8), 6	9.1 (5.7), 10	8.2 (5.3), 6.5	.046
Days ≥5 drinks per month <sup>a</sup>	2.9 (3.1), 2	4.8 (6.5), 3	3.9 (5.1), 2	.040
Use drugs not prescribed <sup>c</sup>	14 (12%)	21 (21%)	35 (16%)	.081
Ever seen a doctor or nurse	70 (60%)	81 (80%)	151 (70%)	.002
Have a place you usually go when sick	61 (53%)	70 (69%)	131 (60%)	.012
Have health insurance	11 (10%)	19 (19%)	30 (14%)	.047
Ever told you had				
High blood pressure	16 (14%)	25 (25%)	41 (19%)	.040
Depression	7 (6%)	21 (21%)	28 (13%)	.001
Arthritis	3 (3%)	15 (15%)	18 (8%)	.001
Diabetes	2 (2%)	5 (5%)	7 (3%)	.180
Asthma	4 (3%)	3 (3%)	7 (3%)	.843
Lung disease	1 (1%)	3 (3%)	4 (2%)	.251
Heart disease	1 (1%)	4 (4%)	5 (2%)	.130
Aware of any health services				.000
Hospital or clinics	83 (72%)	88 (87%)	171 (79%)	
Pharmacy only	3 (3%)	6 (6%)	9 (4%)	
None	30 (26%)	7 (7%)	37 (17%)	
Aware of any social services				.006
Shelter/food and health, legal <sup>d</sup>	31 (27%)	32 (32%)	63 (29%)	
Church, shelter/food only	34 (29%)	45 (45%)	79 (36%)	
None	51 (44%)	24 (24%)	75 (35%)	

<sup>a</sup>Number and percent of column unless otherwise specified; numbers do not add to total if questions were not answered, and percents may not add to 100 because of rounding.

<sup>b</sup>Only asked among those who indicated that they drank alcohol.

<sup>c</sup>Drugs included prescription pain medications as well as street (illicit) drugs.

<sup>d</sup>Participants who indicated knowledge of more than one setting including settings for legal, social services, and assistance specifically for day laborers.



significant at  $\alpha = .10$  to characterize those who reported poor or fair health. Having looked for day labor jobs three years or more and supporting three or more others were each associated with about twice the likelihood of reporting their health as fair or poor.

**Success in obtaining work.** Participants didn't look for work in all four seasons: 7% ( $n=16$ ) did not look for work in Fall, 9% ( $n=20$ ) didn't look in Winter, 4% ( $n=8$ ) didn't look in Spring, and 9% ( $n=20$ ) didn't look in Summer. In an average week, the proportion who tried to find work every day was 52% in Fall, 32% in Winter, 55% in Spring, and 55% in Summer. Success at obtaining work among those who tried is presented in Table 4, divided by season and by time in San Francisco. Overall, participants were successful about one third of the time in obtaining work on the days they looked for work. Those who had been in San Francisco longer than three years were more successful on average (37%) than those in San Francisco three years or less (31%) ( $p = .001$ ). In nearly all analyses by season, participants who were day laborers in San Francisco three years or less were more likely to have waited longer, were less successful in getting picked up for work, and worked fewer hours than those who had been in San Francisco longer than three years.

Success at obtaining work over all four seasons is presented in Table 5. Those who were looking for work in San Francisco longer than three years and those supporting more people had more success in obtaining work as a day laborer, controlling for English proficiency and educational level.

## Discussion

Day laborers in San Francisco are a subset of the population that is often unstably housed. While nearly half reported unstable housing by conventional measures of homelessness or housing instability, over two thirds of those in stable housing had less than optimal living conditions. Further examination revealed that they at least shared rooms and sometimes shared beds with non-partners, and despite housing stability some did not even have a place to store their belongings. Homelessness has been increasingly recognized as far more than simply an issue about housing, but one that reflects a more profound and devastating state that is in itself a health risk,<sup>10,11</sup> especially in the context of the urban setting.<sup>12,13</sup> New ways to measure housing stability that capture shared rooms and shared beds, crowding and lack of privacy may be useful in describing this risk.

Just over half our sample of working men reported their health as fair or poor, and factors associated with fair or poor health were more time in the city as a day laborer, poor English proficiency, and supporting three or more other people. This may be a result of the low socioeconomic status of the sample,<sup>14</sup> and in particular, the impact of limited language skills combined with financial obligations to family living elsewhere. Despite participant knowledge about health care services in the city, only a small proportion was enrolled in Healthy San Francisco, even among those here for longer periods. This lack of participation in the city's health care safety net, taken along with participants' self-reported reasons for not having insurance, reinforce the idea that this population fears engaging in a system that might lead them to deportation.<sup>15</sup>

Urban day laborers in this study were for the most part unsuccessful at their attempts

**Table 3.****CHARACTERISTICS ASSOCIATED WITH PERCEIVED HEALTH STATUS AMONG URBAN DAY LABORERS IN BIVARIATE AND LOGISTIC REGRESSION ANALYSES**

Characteristic	Good/ Very Good/ Excellent		Logistic regression results predicting poor or fair health <sup>a</sup>	
	Poor/Fair N=118 N (%)	N=99 N (%)	Adjusted Odds Ratio (95% CI)	p value
Age				
≤36 years	50%	50%		
>36 years	59%	41%		
Years looking for work in San Francisco				.034
≤3 years	47%	53%	1.9 (1.1, 3.4)	
>3 years	62%	38%	reference	
Years of education				
≤8 years	58%	42%		
>8 years	51%	49%		
Speak English				.058
Not well or not at all	57%	43%	2.3 (1.0, 5.6)	
Very well or well	38%	62%	reference	
Marital status				
Married or living with partner	62%	38%		
Divorced or separated	50%	50%		
Never married	49%	51%		
Stable housing in the past month				
No	50%	50%		
Yes	58%	42%		
Number of others supported				.020
None	48%	52%	Reference <sup>b</sup>	
One other	47%	53%	Reference <sup>b</sup>	
Two others	43%	57%	Reference <sup>b</sup>	
Three or more others	61%	39%	2.0 (1.1, 3.5)	
Any chronic condition <sup>c</sup>				.078
No	49%	51%	reference	
Yes	66%	34%	1.8 (0.9, 3.3)	

<sup>a</sup>Logistic regression results include variables significant in bivariate analysis at alpha = .10.

<sup>b</sup>Supporting none, one, or two others was combined; the reference group was supporting less than 3 others.

<sup>c</sup>Told by a health care provider that he had any of the following: high blood pressure, depression, arthritis, diabetes, asthma, lung disease or heart disease.

**Table 4.****HOURS WAITING, DAYS WORKED AND SUCCESS IN OBTAINING WORK BY SEASON AND YEARS LOOKING FOR WORK AMONG URBAN DAY LABORERS IN SAN FRANCISCO**

	≤3 years Mean (std.dev), Median	>3 years Mean (std.dev), Median	Total Mean (std.dev), Median	p value
Hours/day waiting for work				
Fall	3.0 (2.0), 3	2.2 (1.6), 2	2.6 (1.9), 2	.002
Winter	3.2 (2.0), 3	3.0 (1.9), 3	3.1 (2.0), 3	.435
Spring	2.6 (1.8), 2	2.3 (1.4), 2	2.4 (1.6), 2	.334
Summer	3.2 (2.3), 2.5	2.2 (1.5), 2	2.7 (2.0), 2	.001
Hours/day worked				
Fall	5.7 (2.3), 6	6.3 (2.2), 7	6.0 (2.3), 6	.076
Winter	3.9 (2.0), 3	4.5 (2.3), 4	4.2 (2.2), 4	.034
Spring	6.0 (2.3), 6	6.5 (1.9), 7	6.2 (2.2), 7	.089
Summer	5.9 (2.4), 6	6.9 (2.2), 7	6.4 (2.4), 7	.005
Success <sup>a</sup>				
Fall	32%	37%	34%	.020
Winter	26%	29%	28%	.175
Spring	33%	39%	36%	.003
Summer	33%	40%	37%	.009

<sup>a</sup>Success in obtaining work was calculated as the number of days work was obtained divided by the number of days looking for work in an average week.

to find work. Longer time in the city was associated with a higher likelihood of success in obtaining work as a day laborer, but this finding is not easily explained by cross-sectional data. On the one hand, the longer a person is trying to find work, the more likely he is to learn the system and gain skills in self-marketing.<sup>16</sup> Similarly, those who supported more people, here, in other parts of the U.S., or outside the U.S., were more successful. But these one-time and limited data do not provide insight as to whether this was because of learning and determination, or because those who had not been successful left the area.<sup>17</sup>

The data from this study reflect the reality of a population under a great deal of stress from looking for daily work on street corners in a worsening economy, separation from family and unstable housing. This stress combined with a lack of knowledge of and access to health care puts urban day laborers at an increased risk for disease conditions associated with poor physical and mental health. Based on these findings, several strategies for managing stress and improving the knowledge of and access to health care can be made. First, while Healthy San Francisco is available to all San Francisco residents regardless of immigration status, employment or pre-existing medical conditions,

**Table 5.**

**SOCIODEMOGRAPHIC AND HEALTH-RELATED  
CHARACTERISTICS ASSOCIATED WITH SUCCESS<sup>a</sup> IN  
OBTAINING WORK AMONG URBAN DAY LABORERS IN  
BIVARIATE AND LINEAR REGRESSION ANALYSES**

Characteristic	% Success	Linear regression results <sup>b</sup>	
		Beta	p value
Age			
≤36 years	34%		
>36 years	33%		
Years looking for work in San Francisco		.060	.000
≤3 years	31%		
>3 years	37%		
Years of education		.016	.341
≤8 years	32%		
>8 years	35%		
Speak English		.047	.073
Not well or not at all	33%		
Very well or well	39%		
Marital status			
Divorced, separated or never married	32%		
Married or living with partner	35%		
Stable housing in the past month			
No	32%		
Yes	35%		
Number of others supported		.025	.001
None	29%		
One other	31%		
Two others	31%		
Three or more others	36%		
Any chronic condition <sup>c</sup>			
No	34%		
Yes	34%		
Perceived health status			
Good, very good or excellent	34%		
Fair or poor	33%		

<sup>a</sup>Success in obtaining work was calculated as the number of days work was obtained divided by the number of days looking for work in an average week across all seasons.

<sup>b</sup>Linear regression results include variables significant in bivariate analysis at alpha = .10.

<sup>c</sup>Told by a health care provider that he had any of the following: high blood pressure, depression, arthritis, diabetes, asthma, lung disease or heart disease.

one must go to an enrollment site to enroll in the program. More often than not, the enrollment site is at the health department or other community-based health center. Additionally, to prove eligibility, a person must provide a photo identification document, proof of residency, and proof of income and assets. While the documentation requirements are liberal, they may be overwhelming for a day laborer. Work centers and other community-based organizations available to day laborers can provide the support this population needs to enroll in the Healthy San Francisco program by helping the day laborer obtain the appropriate documentation and helping them navigate the process.

Second, there is a need to provide primary health care to day laborers in non-traditional settings. In San Francisco, the Day Labor Program housed at La Raza Centro Legal provides a weekly medical clinic and social worker for its patrons. However, expansion of this program is greatly needed to include mobile units and hours accessible to day laborers so that the opportunity for work is not missed.

Lastly, Walter, et al.<sup>18</sup> make three recommendations to improve clinical interactions and further the health and well-being of this vulnerable population: (1) recognize day laborers and ask about their work circumstances, (2) build a therapeutic relationship to gain their trust, and (3) work with day laborers to promote their health and safety. By gaining the trust of the day laborer, the health care provider may obtain valuable information to assist in the identification of stress-related depression and unhealthy behaviors. Referrals can then be made to shelters, advocacy groups, and legal aid and social service agencies to address the specific needs of this population.

These findings add to the small but growing literature on the living and family situations, health status, and success in getting work of urban day laborers. This study is limited by its cross sectional design. Additionally, the population of day laborers represented in this study are those who seek employment at the local work center and at street corners. There may be other locations we missed and those day laborers may have notably different characteristics than the participants of this study. Finally, while a number of efforts were made to establish trust and a safe environment to engage with day laborers who participated in our study, through hiring and training culturally sensitive staff, consulting with advocacy groups such as La Raza Centro Legal who are familiar with the challenges and social context of this population, conducting interviews in private locations, and emphasizing the confidentiality of our research through the process of informed consent, distrust of researchers may have affected the information participants were willing to disclose. In order to understand more fully the lives and work of urban day laborers and how acculturation may affect their health and social conditions, longitudinal studies are needed. Important questions should be addressed: what happens to workers as they learn the system; who leaves for permanent work; and what are markers of success? The information gathered from this study as well as future information on the strengths and resilience of this population can be used to create culturally responsive and appropriate services.

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