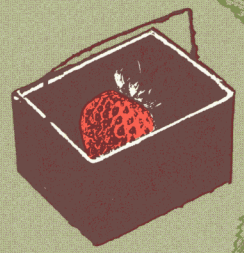
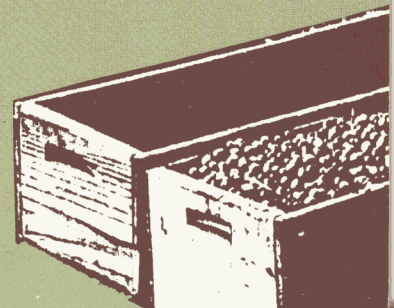
HIV/AIDS:

A Growing Crisis Among Migrant and Seasonal Farmworker Families





NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

Some of the pictures throughout this report, taken in the 1930s by the Farm Security Administration (FSA), testify to the fact that farmworkers lived in substandard housing conditions, worked long hours in often dangerous fields, nurseries, and orchards for little pay, and suffered a variety of health and social problems.

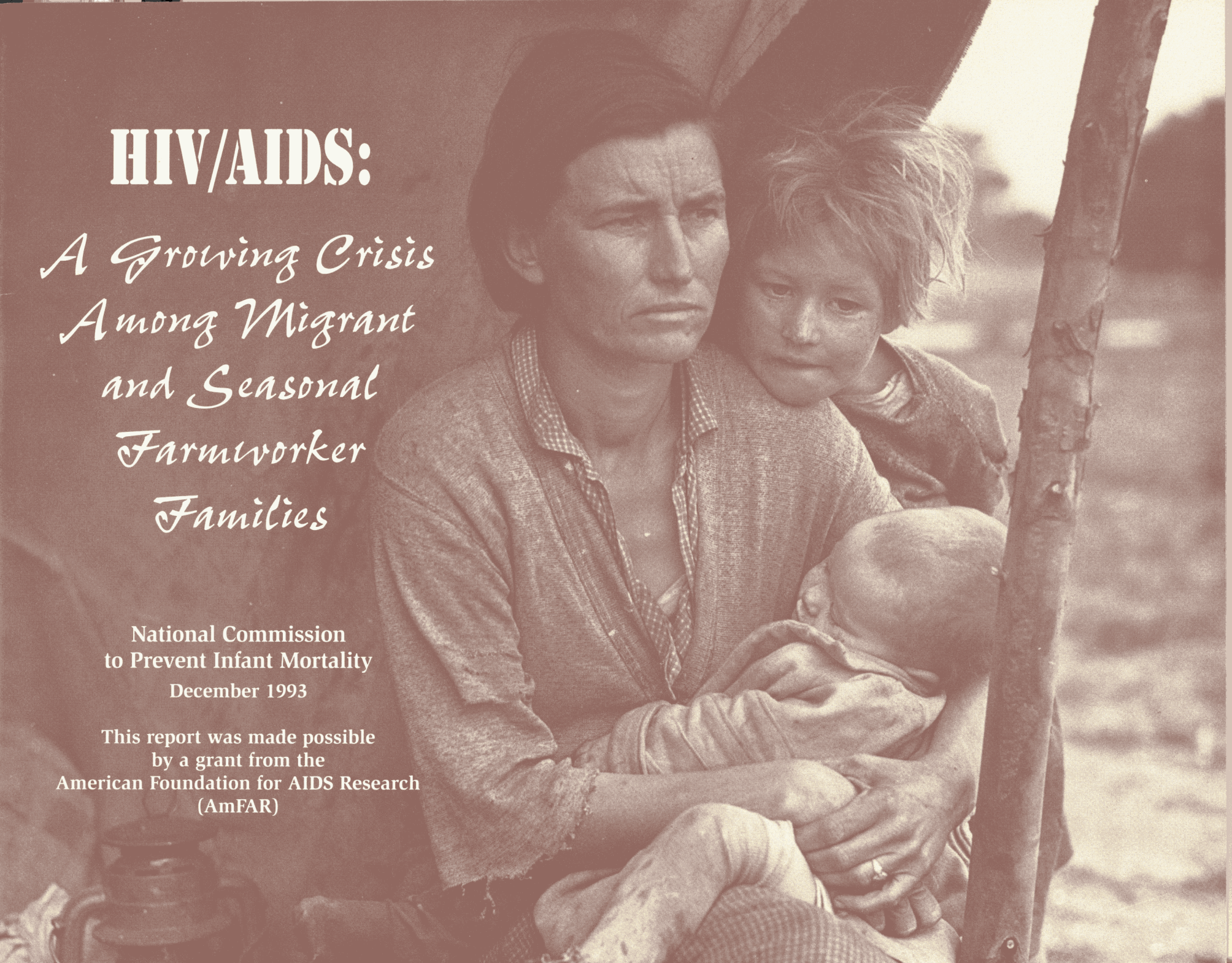
During the late 1930s and early 1940s, FSA built Farm Security Camps to provide housing and basic health services to migrant farmworkers. This program was terminated in 1947.

In the 1960s the federal government took on the responsibility of improving the health and well-being of migrant farmworkers by instituting health, education and social service programs specifically for farmworkers. One of these was the Migrant Health Program, instituted by the Migrant Health Act of 1962.

Sadly, despite these programs and the overall improvement in the health and well-being of most people throughout the country in the past 60 years, conditions for farmworkers began to decline further during the 1970s. Today, farmworkers represent one of the poorest segments of American society in both health and economic status.

And now, men, women and children who come to harvest the crops in the migrant streams of the United States face a new and more ominous threat: HIV and AIDS, and the potential devastation this epidemic brings to their families, future generations and to the nation.

Photo: Library of Congress—Nipomo, California—Dorothea Lange, 1936



HIV/AIDS:

A Growing Crisis Among Migrant and Seasonal Farmworker Families

National Commission
to Prevent Infant Mortality

December 1993

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(AmFAR)

Contents

Executive Summary

Migrant and seasonal farmworkers in the United States are a heterogeneous group with various ethnic/racial backgrounds including Hispanic/Latino, Black/African-American, Jamaican, Haitian, Hmong and Anglo among others. The Office of Migrant Health, Department of Health and Human Services, estimates the farmworker population (farmworkers and their dependents) to be 4.1 million, with approximately 1.6 million being migratory[1].

"... HIV disease has begun spreading to farmworker women and children, most of whom are unaware that they are at risk and unable to take precautions to protect themselves from HIV."

A confluence of factors such as hazardous working conditions, low wages, chronic underemployment, sub-standard housing conditions, limited education, poor health, and for migrant farmworkers, constant mobility, put farmworkers at risk for myriad health and social problems. Lack of access to health care due to financial, geographical, cultural, and linguistic barriers coupled with often scant material and social support resources cast farmworkers into a high-risk arena for exposure to HIV disease.

A review of the literature shows the following among farmworkers:

- rates of HIV higher than those found in the general United States population;
- high rates of risk factors for the spread of HIV infection such as sexually transmitted diseases, tuberculosis, and substance abuse;
- limited understanding of HIV prevention measures; and
- limited resources and skills to protect themselves from and treat HIV/AIDS.

What little research has been done on HIV/AIDS in the farmworker population focuses primarily on rates among male farmworkers. However, HIV disease has begun spreading to farmworker women and children, most of whom are unaware that they are at risk and unable to take precautions to protect themselves from HIV. The illness and eventual death of a farmworker woman will have devastating effects on the health and well-being of the

farmworker family because in many cases she not only provides economic support but also is the primary caretaker in the family system.

This report is the centerpiece of a project developed by the National Commission to Prevent Infant Mortality, through a grant from the American Foundation for AIDS Research (AmFAR) to focus attention on HIV/AIDS among farmworker families. For this report, health and social service providers working with migrant and seasonal farmworkers were surveyed regarding their perceptions of HIV/AIDS among farmworkers and descriptions of available services that address HIV/AIDS in the farmworker community. Their responses not only confirmed previous research findings, but also painted a picture of a population teetering on the brink of a disastrous epidemic. Most notably:

- Migrant and seasonal farmworkers are contracting HIV in significant numbers, and rates appear to be increasing;
- Farmworkers are disproportionately subject to "facilitating factors" — conditions that promote HIV transmission — such as sexually transmitted diseases, and alcohol and other drug use; and
- Farmworkers often lack access to prevention, treatment, and educational services that can curb the spread of HIV/AIDS.

All those surveyed felt the clock was ticking and that immediate action was vital to curb the spread of HIV/AIDS among farmworkers. Their recommendations for action included:

- Congress should allocate monies for farmworker-specific HIV/AIDS data collection and research;

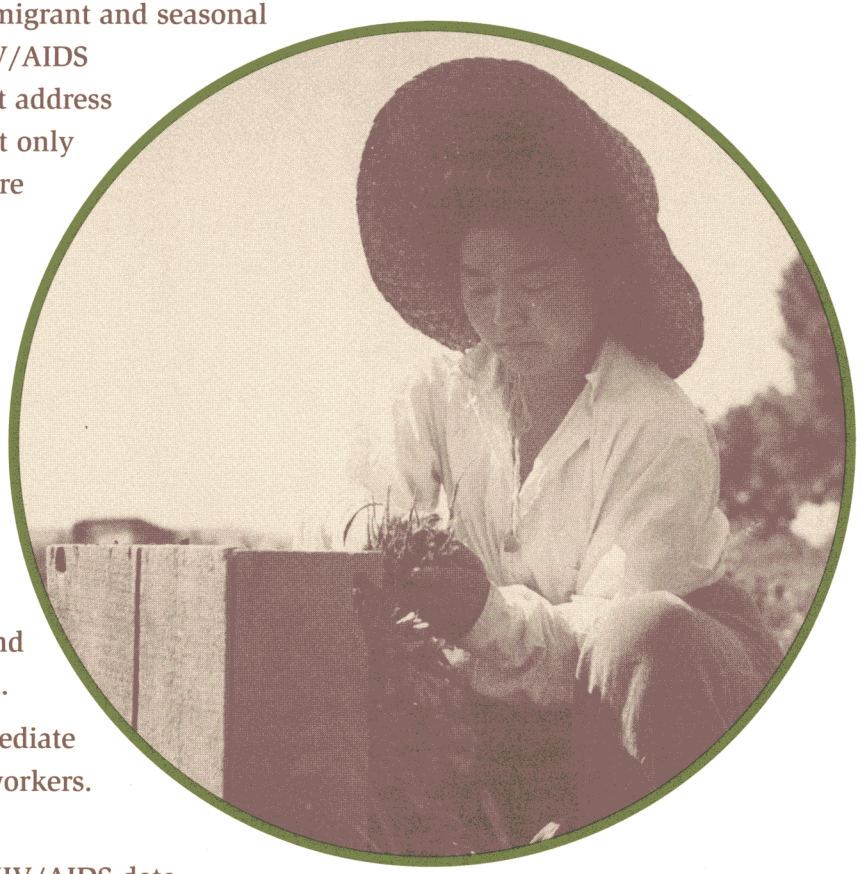


Photo: Library of Congress—Nyssa, Oregon, 1942

- Congress should appropriate additional funds to programs that target farmworker health and HIV/AIDS and encourage coordination between maternal and child health, farmworker, and AIDS programs;
- The Secretary of Health and Human Services should establish the prevention and treatment of HIV/AIDS among farmworking women and children as a priority in federal health service programs that target women and children in general and farmworkers in particular;
- Grant requirements for federal HIV/AIDS funding sources should require community-wide planning and needs assessments, and farmworkers should be included in this planning;
- To provide effective HIV/AIDS services to farmworkers, federal, state, and local programs need to incorporate bilingual/bicultural services, and linguistically, culturally and gender-matched materials and methods into current programs;
- Federal and state governments should increase funding for targeted outreach to farmworkers for effective HIV prevention/treatment; and
- The health care needs of migrant and seasonal farmworkers should be included in all federal and state health care reform plans, and current public health programs, such as migrant health centers and others serving farmworker families, should be maintained and strengthened.

Photo: U.S. Department of Agriculture

In June 1993, a 28-year-old farmworker woman died, leaving three children behind. Three years earlier, she had come to the migrant health center complaining of headaches. She was treated for the headaches and was not required to return for follow-up. Two years later she returned to the clinic for treatment of a urinary tract infection. Clinic staff learned she had just been hospitalized for pneumonia and meningitis. A review of her hospital records confirmed her HIV positive status. Although the migrant health center staff discussed the need for her to obtain additional services, she left the clinic and did not return.

A concerned nurse at the clinic attempted to find her. She was able to contact the woman's husband, who told her he was working 16 hours a day to pay for his wife's AZT. The nurse explained that the clinic could get assistance for his wife. The woman allowed the nurse to visit her and agreed to go to the clinic for a T-cell count test.

The woman's T-cell count was extremely low, signalling that her immune system was significantly compromised. Miraculously, she was able to survive with this low count for two years. But those two years were difficult. The woman's husband was threatened with loss of his job for absences to take her to clinic appointments. The woman's condition deteriorated.

With great effort, the health center nurse connected the woman with hospice services, a visiting nurse network, and the AIDS network, which provided her medications. However, this help ran out after two months and new resources were not found. The woman became very sick and very depressed. Her older children (age 6 and 7) had to care for her. Soon after, she was hospitalized for six weeks. At that time, she asked to be discharged because she knew she was dying. She remained in a coma for two weeks at home before she died.

Prior to her death, the woman told the nurse she had received a blood transfusion after her last baby was born and assumed this was how she had been infected. Her husband, out of fear, staunchly refused to be tested or to let the children be tested. The woman's mother asked the husband's permission to take the children with her back to Texas. The nurse had asked the grandmother to supply information on the baby because of the remaining question of his HIV status. She has not heard from the grandmother since.

Introduction

Although we depend on migrant and seasonal farmworkers to harvest the food that keeps our nation healthy and helps maintain our status as the worldwide leader in agricultural output, farmworkers and their families often are a forgotten group of people. Hired farmworkers often encounter occupational hazards such as lack of drinking water and sanitary facilities, and may be exposed to extreme weather conditions and dangerous pesticides. Compounding this, a confluence of factors not commonly considered "occupational risks" but nonetheless associated with being a farmworker include low pay, chronic underemployment, sub-standard housing conditions, limited education, poor health and, for those agricultural workers who follow the harvest, constant mobility. These factors come together to make farmworkers and their families a population at risk for many health and social problems.

For many marginalized groups in the United States, the Acquired Immunodeficiency Disease (AIDS) epidemic represents the greatest threat to well-being thus far encountered. As more and more people are infected with Human Immunodeficiency Virus (HIV), the virus that causes AIDS, those battling on the front lines are coming to understand the relentless manner in which HIV disease plays out among people who, due to life circumstances, have limited access to the financial, health, social and emotional support services that help fight HIV infection. Migrant and seasonal farmworkers are among the least powerful groups in our society. The threat that HIV poses to them goes unexpressed, and, for the most part, unaddressed by the society at large.

Little formal research has been done regarding HIV/AIDS in farmworkers; until now, no national group has focused attention specifically on the effect of the epidemic on farmworker families, particularly women of childbearing age and their children. However, the problem is obvious to those working with migrant and seasonal farmworkers, and it is growing. HIV disease and eventual

"HIV disease and death from AIDS in farmworker women will devastate farmworker families, not only because the disease can be transmitted to their children, but also because farmworker women are usually the primary caretakers in the entire family system."

death from AIDS in farmworker women of childbearing age will devastate farmworker families, not only because HIV can be transmitted to their children, but also because farmworker women are usually the primary caretakers in the entire family system.

Most importantly, the current system of health care, social services and support available to this population is not prepared to deal with this growing crisis. An epidemic of HIV/AIDS among farmworkers also would be devastating for us as a nation, given the vital role farmworkers play in the United States' agriculture industry.

In April 1993, the National Commission to Prevent Infant Mortality, with a grant from the American Foundation for AIDS Research (AmFAR), initiated an action plan to focus attention on the issue of HIV/AIDS among farmworker families, specifically highlighting the effects of the disease on farmworker women and children.

Goals for this report include: 1) raising awareness among policymakers, elected officials, health and education professionals, and others regarding HIV/AIDS in farmworkers, particularly farmworker women of childbearing age and children; 2) recommending specific action steps that can be taken now to address this escalating problem.

This report must not be left on a shelf to gather dust. It must be used to educate and convince decisionmakers to take action. This report provides the most current information from the perspective of health and social service providers who are working with farmworkers about the direct effect HIV/AIDS is having on farmworker communities and the extent to which services are being provided. In addition, the report describes policy changes and action steps that must be taken to reduce the threat HIV poses to the farmworker community.

As such, it represents one piece in the horrible puzzle that is HIV/AIDS, an epidemic that threatens the health of our entire nation.

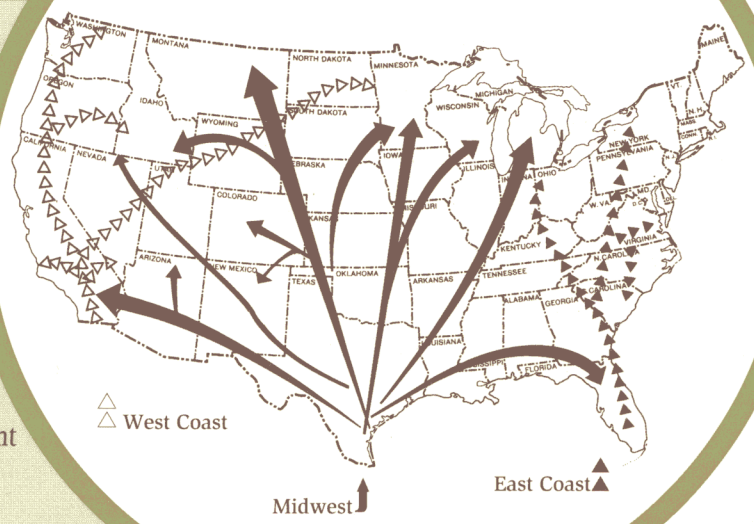
Photo: National Archives—
Cotton growers' camp, Arizona—
Dorothea Lange, 1940

Farmworker Families

The phrase "migrant and seasonal farmworkers" includes those who migrate and a larger number of non-migrants who turn to agriculture annually during peak harvesting and/or processing times.

An estimated 70 percent of the farmworker population is Hispanic/Latino, with Black/African-Americans making up the next largest group. The majority of seasonal farmworkers are married and/or have children. Contrary to popular belief, around 27 percent of foreign-born farmworkers are either naturalized citizens (2 percent) or legal permanent residents (25 percent). Moreover, 81 percent of foreign-born farmworkers, including Hispanics, are legally authorized to work in the United States[2].

The Major Migrant Streams



Source: National Migrant Referral Project, Inc. (NMRP)

Migrant farmworkers typically labor in three major agricultural streams in North America: the West Coast, Midwest, and East Coast streams. These labor streams originate in "home-base" states such as California, Texas, and Florida, and follow the crops north throughout the harvesting season. However, recent migration has been following a less distinguishable pattern. Farmworkers now often travel to any part of the country that has agricultural work, particularly when some agricultural areas of the country suffer a natural disaster, such as the 1993 flooding of the Mississippi and Missouri rivers.

In some areas single males travel the stream in crews of 20 to 40 without their families (an estimated two in five of all farmworkers). In other areas, significant numbers of families are working the migrant streams, with an estimated one third of the migrant population being women and children[2].

Limited economic resources, coupled with the transient lifestyle of migrant farmworkers, make this population a medically compromised group. Approximately 80 percent of migrant farmworkers do not have any type of health insurance, public or private. Farmworkers and their families often have difficulty qualifying for, enrolling in and maintaining eligibility for Medicaid for a number of reasons. Adult male farmworkers are rarely eligible on their own, many farmworkers travel from state to state and stay for only short periods in one area, and in some areas, some farmworking men, women, and children are undocumented.

Overview

HIV/AIDS In The United States

More than 1.5 million people in the United States are estimated to be infected with HIV, the virus that causes AIDS, and 315,390 cases of AIDS have been diagnosed through June 1993 [3,4]. The AIDS epidemic has grown to become a primary public health crisis in the United States, representing the leading cause of years of potential life lost. The projected cost of treating people with HIV/AIDS in 1994 is $13.49 billion[5].

Women are the fastest growing group of people with AIDS, making up 11 percent of all reported cases[6]. The Centers for Disease Control estimate that approximately 110,000 women in the United States are infected with HIV. An estimated 6,000 HIV-infected women are expected to give birth to children each year, approximately 1,500 to 2,000 of whom will be infected with HIV[7].

Through June 1993 in the United States, 4,710 cases of AIDS had been reported in children under age 13, with perinatal (mother to unborn baby) transmission the risk factor in 87 percent of cases[4]. AIDS threatens to rise to the fifth leading cause of death within the next 10 years among children of all ages in this country[8].

Blacks/African-Americans and Hispanics/Latinos are disproportionately represented among those with HIV/AIDS, and the disease is expected to spread at much higher rates among these groups than others in the coming decade[9]. Most farmworkers belong to these two racial/ethnic groups. Of women reported to have AIDS in the United States, 53 percent are Black/African-American and 21 percent Hispanic/Latina, making them 15 and 9 times more likely, respectively, to have AIDS than White/Anglo women[6].

Transmission of HIV occurs only through blood-to-blood or sexual contact, or from mother to infant. AIDS risk is greater for populations with a higher incidence of behaviors that can transmit the virus. However, the spread of the disease is rapid and relentless among medically underserved populations, which include farmworkers, and others living in poverty. This is because diagnosis is often late or non-existent and prevention information is not well disseminated or often not culturally appropriate.

"... the spread [of HIV/AIDS] is rapid and relentless among medically underserved populations, which include farmworkers and others living in poverty."

Case Study: Chantal

Chantal is a 42-year-old Haitian farmworker woman, living on a farm in the eastern migrant stream. Over the last two years, she visited the multi-county community health center many times for various symptoms and was finally given an HIV test. The finding was positive.

Chantal now has AIDS. She left the area last November to work in Florida but returned to the health center late last spring for treatment. The resources needed to treat Chantal's disease have been extensive. She must be transported once a week to an HIV clinic located 120 miles away. Because she is non-English speaking, a translator must accompany her to each appointment. Fortunately, two students who speak Creole and attend the local university have been hired for translation purposes.

Chantal was hospitalized for over a month this summer. She is receiving home visits from a nurse now, the cost being covered by county assistance funds. Although the state HIV treatment program covers her portable oxygen and medications for AIDS-related conditions, medications for other complications such as mouth sores (Mycelex/$27/month) and stomach pains (Zantac/$95/month) are not covered and are being absorbed by the community health center.

Chantal is unable to work now, and though poor, unable to obtain Medicaid because she is undocumented. The clinic is committed to helping her, but the staff must be creative in finding resources. They are concerned that this band-aid approach will not suffice when HIV infection is found in more than one or two farmworkers in the area.

HIV/AIDS Among Migrant and Seasonal Farmworker Families

Calls to action on behalf of migrant and seasonal farmworkers are often stymied by a lack of data on the health and social status of this population. National data are not routinely collected and local level research (identifying health patterns among farmworkers, issues concerning access to services, and other matters that could help highlight areas in need of attention) is almost non-existent. The following summarizes the limited research related to HIV and AIDS among farmworkers that has been conducted.

A recent Centers for Disease Control and Prevention study of farmworkers in Immokalee, Florida, (of whom 90 percent were male) found the rate of HIV infection to be 5 percent— a full ten times that of the general population[10]. Rates of infection found in other studies among sampled groups of farmworkers working in the eastern migrant stream have ranged from a low of 2.5 percent in North Carolina to 13 percent in rural South Carolina[11,12,13].

Little formal research has been done on farmworker women. By virtue of the fact that they are the sexual partners of farmworker men, they are at risk. Moreover, infected women can pass the virus to their unborn children. An estimated 25-30 percent of children born to infected mothers will also be infected. Anecdotal sources are in broad agreement in their descriptions of farmworker women's lack of knowledge of their partners' risks, decreased ability to take action to protect themselves from sexually transmitted diseases such as HIV, and inability to readily obtain preventive health care services and information about HIV. In addition, HIV infection has been increasing dramatically among Hispanic/Latina and Black/African-American women in the United States, two groups to which the majority of farmworker women belong. Transmission by heterosexual means is more common or becoming more common than transmission by other means in some farmworker women's countries of origin, such as Latin America and the Caribbean[14].

Risk Factors for HIV Infection Among Farmworker Families

HIV is transmitted more easily in the presence of certain health conditions and behaviors such as sexually transmitted diseases, tuberculosis, and alcohol and illicit drug use. Rates for these facilitating factors appear to be significantly higher among the farmworker population compared to the overall United States population. Farmworkers also have been found to lack knowledge about HIV and to participate in risk behaviors that increase exposure to the virus.

- **Sexually Transmitted Diseases:** In Immokalee, Florida, 8 percent of tested farmworkers were positive for syphilis, compared to a national level of 0.8 percent[10]. Lack of knowledge about STDs, limited access to health care, language barriers, mobility, and infrequent use of condoms contribute to the spread of STDs, including HIV, among farmworkers[15].
- **Tuberculosis:** Recent studies show that 35-45 percent of farmworkers tested are infected with tuberculosis[16,17,18,19,20]. People infected with both HIV and tuberculosis develop tuberculosis disease much more readily than tuberculosis-infected

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persons without HIV, and can die of tuberculosis as their HIV opportunistic infection in a matter of months.

- **Substance Abuse:** Anecdotal sources document considerable use of chemical substances among farmworkers, particularly young adult males, stemming from the loneliness, unemployment, and poverty associated with being a hired farmworker and living in a labor camp[21].
- **Lack of Knowledge about HIV and Risk Behaviors:** Surveys of farmworkers' knowledge of HIV transmission describe a general lack of knowledge regarding modes of transmission and methods of prevention[22,23]. In addition, significant percentages of farmworkers are participating in behaviors that put them at risk for transmission of the HIV virus such as: 1) sexual intercourse with multiple partners[10,22,23,24]; 2) vaginal or anal intercourse without using a condom (up to 47 percent)[10,22,23,24]; 3) sexual intercourse with prostitutes (who may be using injectable drugs)[23,24]; and 4) self-injection of therapeutic drugs such as vitamins and antibiotics, often with shared needles[25].

Federal Programs Currently Available for Migrant and Seasonal Farmworker Families

While farmworkers may receive care through various health, nutrition, social, and educational programs, some federal programs specifically target migrant and seasonal farmworkers. However, these programs are administered separately and have different definitions of "migrant" versus "seasonal" farmworker, as well as varying eligibility standards, all of which create barriers to program coordination.

The four largest federal programs specifically serving farmworkers are:

- **The Migrant Health Program**, run by the Bureau of Primary Health Care within the Department of Health and Human Services, funds approximately 400 clinic sites operated by 106 grantees in 43 states. A separate program of federally funded Community Health Centers for "medically underserved" areas also serves some migrant communities. Approximately 80 percent of Migrant Health Centers are jointly funded with Community Health Centers, and such programs provide services both to their entire local community and to farmworker specific sites. Community and Migrant Health Centers do not receive earmarked funds for AIDS care under their base funding, although they are expected to provide comprehensive primary care, are free to provide all AIDS services that primary care calls for, and may do this by seeking targeted funding for AIDS.
- **The Migrant Education Program,** administered by the Department of Education, provides special supplementary funding to state education agencies to enhance education for migrant school-age children. No specific funds for health care or health education are set aside within the Migrant Education Program, but states may choose to use some funds for health purposes. Although some programs are providing some form of HIV/AIDS education, academic record keeping systems within the Migrant Education Program do not place special emphasis on tracking the participation of a migrant student in AIDS education or other health education classes. The Migrant Student Record Transferring System was developed to transfer academic records of migrant students and includes a section for health information.

- **Migrant Head Start,** administered by the Administration on Children and Families in the Department of Health and Human Services, operates through 23 grantees adapting the Head Start comprehensive preschool child development program to the special needs of migrant children. However, unlike Head Start which serves children ages 2-5, Migrant Head Start targets migrant children from birth through age 5. Although no specific requirement exists to provide HIV/AIDS prevention education to the parents of Migrant Head Start students, many agencies have held parent workshops on AIDS and other health education topics.
- **Title IV, Section 402 of the Job Training Partnership Act (JTPA),** administered through the Department of Labor, helps farmworkers gain skills needed to move into more stable, nonagricultural employment. Grantees may also spend up to 15 percent of their funds on "non-training-related support services," that may include health care, shelter, and meals, all of which could be important to farmworker families trying to better their standard of living. Many JTPA grantees are also Migrant Head Start grantees. Some have been able to obtain other sources of private and public funding, which include AIDS education monies and community service block grants.

Photo: Pregnant woman living in a car—Alan Poque © 1991

Other programs providing health services to farmworker women and children include:

- **The Medicaid Program** funds health services for the poor, primarily women and children, through reimbursement of provider costs. It is funded by both state and federal governments but is primarily administered by the states. Few migrant farmworker families are able to access Medicaid due to mobility from state to state, documentation, and other problems meeting eligibility requirements.
- **The Maternal and Child Health Block Grant Program (Title V)** has as its overall goal the improvement of the health of all mothers and children in the nation. The bulk (approximately 85 percent) of funds are distributed to the states to directly provide or otherwise help assure access to quality health care for mothers and children, especially those with low incomes. Funds also assist children with

special health care needs to obtain the range of services they need. This program forms the core of public health services for pregnant women and their children.

- **The Special Supplemental Income Program (SSI),** administered by the Social Security Administration, provides cash assistance and medical payments for people who are unable to work because of a physical or mental impairment or combination of impairments that can be expected to last at least one year or result in death. The Administration is in the process of revising program guidelines to improve access to services for HIV-infection among women, drug-addicted, and low-income individuals.

Unfortunately, even when taken together, the federal programs serving migrant and seasonal farmworkers are unable to reach all farmworkers, and some serve only a small proportion of the population. For example, clinics funded through the Migrant Health Program are estimated to reach less than 15 percent of the population.

Moreover, although the Migrant Health, Migrant Education, and Migrant Head Start programs are providing HIV prevention services in one form or another, these efforts cannot possibly meet the need. Budgets are very limited and funding is not specifically targeted for HIV education, screening, and treatment within any of these programs.

Federal Funding for HIV/AIDS Research, Prevention and Treatment

Various federal programs in the Department of Health and Human Services provide funding for HIV/AIDS-related activities at the local level, including the **Centers for Disease Control and Prevention's HIV, STD, and TB programs, the Health Resources and Services Administration's Ryan White CARE (Comprehensive AIDS Resources Emergency) Act programs,** including the Pediatric/Family HIV Demonstration program (Title IV), the **National Institutes of Health research activities,** and the **Substance Abuse and Mental Health Services Administration's substance abuse prevention programs** (See Appendix for full description of these programs).

Priorities for funding for these programs are based on need as determined by rates of HIV/AIDS and populations at risk. In the rural areas in which farmworkers live and work, HIV/AIDS appears to be increasing dramatically, particularly among women. However, people in rural areas often have limited access to health care, and it is difficult to document this surge for prevention funding purposes.

Only limited funding for HIV/AIDS services goes to rural health departments for counseling, testing, referral and partner notification and to Migrant and Community Health Centers for targeted HIV/AIDS services, since it has been difficult to document the need with hard data. In addition, substance abuse prevention and treatment services are practically non-existent.

Although it is clear that farmworkers are at risk for contracting HIV, farmworker service organizations have difficulty documenting this need when applying for HIV/AIDS funding. Moreover, because rural areas in general have this problem, farmworker health centers and

clinics also do not have available the same sort of referral network of AIDS organizations and services as might be found in the urban centers that were first hit by the epidemic. HIV/AIDS prevention must begin now in these rural areas, and farmworkers are a population specifically at risk. However, the current system must become more flexible, resourceful, and better funded to meet this challenge.

Photo: Southwest Florida clinic—
Alan Poque © 1988

Case Study: A Family Living With AIDS

Juan is a 31-year-old Latino man who immigrated from Mexico to the United States to do farmwork in the Midwest stream six years ago. He was diagnosed as HIV positive in March of 1991. He believes he was infected heterosexually, most likely from exposure to an infected prostitute who used IV drugs.

Juan has been married to 17-year-old Lupe for three years. Lupe was diagnosed HIV positive in September of 1991. The suspected mode of transmission is heterosexual, through exposure to her husband.

Lupe and Juan have two children, an HIV negative son born in February, 1992 and an HIV positive daughter born in May, 1993. The daughter was hospitalized for pneumonia at one month of age.

Currently, both Juan and Lupe are unemployed. They are renting a one room house through a rent assistance program of the local AIDS Council. They are not eligible for Medicaid due to insufficient documentation, but are able to receive services through the Special Supplemental Food Program for Women, Infants and Children (WIC) and Food Stamp programs.

Juan and Lupe do not have a car, telephone, or refrigerator. They are able to get some of their health care needs met at a community health clinic, although even its supplemental AIDS funding is unlikely to meet all of their and their children's needs in the future.

HIV/AIDS Among Farmworker Families: A Service Provider Survey

Photo: Library of Congress—Arthur Rothstein, 1938

Survey Design

This study collected data from approximately 60 farmworker service program representatives, mostly by telephone, using an interview schedule mailed in advance. A base number of providers, split evenly across the three major migrant streams (East, Mid, and West) was selected from areas known to have a high incidence of HIV among farmworkers along with those considered to have a lower incidence. Participants were asked to give referral names for subsequent rounds of interviews. Most of the providers interviewed work at health centers and clinics providing services for farmworkers. Individuals representing Migrant Education and Migrant Head Start programs and providers from local health departments were also interviewed.

The interviews were approximately one hour in length and focused on determining the service provider perspective on the effects of HIV/AIDS on farmworkers. However, excellent resources and important perspectives on the issue are to be found in the farmworker community as well. Therefore, a future project should follow-up the work begun by this project, possibly using the focus group method to determine farmworker perceptions of the effects of HIV disease among farmworker families.

In the first part of the interview, providers were asked to describe how HIV/AIDS has affected farmworkers in their community. Providers gave their perspective on issues related to HIV/AIDS among three groups of farmworkers seen by their organization: a) those infected; b) farmworkers in general; and, c) women and children in particular. In the second part of the interview, services for HIV prevention education, screening, and treatment were described. Finally, recommendations for policy change at the local, state and federal levels were ascertained.

Findings

While respondents represented sites that differed in size and location, common patterns emerged concerning HIV awareness, risk factors, and barriers to HIV

prevention. Findings below are often given only in overall terms, or by stream for the sake of confidentiality and due to constraints of the data.

The interviews support and significantly expand on the previous research that has been done on HIV/AIDS and farmworkers. The interviews indicate that farmworkers are contracting HIV in significant numbers, experiencing high rates of sexually transmitted diseases, tuberculosis, and substance abuse, and engaging in behaviors that put them at high risk for exposure to HIV.

In addition, the interviews revealed that although HIV prevention education and screening services are available in many communities, financial, linguistic, cultural, employer (long working hours with limited leave) and transportation barriers often limit the accessibility of these services to farmworkers. Moreover, HIV treatment services are lacking in rural communities. This creates barriers for farmworkers, given the challenges discussed above, coupled with the fact that farmworkers are often not eligible for programs such as Medicaid through which they could obtain special HIV support services. HIV-infected farmworkers are often left in dire straits and the health centers and other agencies that are trying to serve them in a desperate search for funding sources and staff support.

Three overall themes were noted throughout the interviews:

1) the impact of community attitudes on the provision of HIV and other health services to farmworkers;
2) the response of farmworkers to the diagnosis of HIV/AIDS; and
3) the effect of cultural and linguistic variations on service provision for farmworkers.

Local Residents' Attitudes toward HIV and Farmworkers

Respondents described some local residents as believing that farmworkers are necessary to harvest the crops and thus, are a valuable addition to the community. Other residents were described as feeling threatened by the presence of farmworkers and their need for health and social services, asserting that they are straining already limited resources.

In addition, interviewees reported that many communities are struggling to adjust to large numbers of people entering their community who speak languages other than English and have

"Three overall themes were noted throughout the interviews:

1) the impact of community attitudes on the provision of HIV and other health services to farmworkers;

2) the response of farmworkers to the diagnosis of HIV/AIDS; and

3) the effect of cultural and linguistic variations on service provision for farmworkers."

customs different from the majority of long-time residents. This struggle often is expressed through prejudice and discrimination.

Finally, some community members may have formed their own views about HIV and its sources, believing that "all farmworkers have it" and represent a threat to their health and to that of their families and their community. Although all clinics receiving migrant health monies should be providing HIV/AIDS prevention services, fear may prevent a community from coming together to address the issue. For instance, a migrant clinic, if isolated from the general community, is in a much less competitive position to apply for federal AIDS funding than it would be in concert with other community providers.

Infected Farmworkers' Response to HIV/AIDS

The second theme pertained to how farmworkers reacted to an HIV/AIDS diagnosis. Once HIV-infected, farmworkers have been found to drop out of their family, their crew, or the farm work-force altogether, making surveillance and treatment efforts difficult. Many infected farmworkers move to cities in order to be closer to HIV treatment services, but such a move often leaves farmworkers little choice but to join the ranks of the homeless, another population at high risk with limited access to services. Other farmworkers return to their countries of origin to seek social support from their family, even though many of these countries offer limited treatment for HIV-infected people.

Most respondents described the difficulty inherent in providing HIV/AIDS surveillance and treatment efforts for HIV-infected farmworkers in light of this dynamic flow, a challenge that could be lessened if an interstate record transfer system and/or cross-border information exchange systems were created. Currently, such systems are lacking, and farmworkers that leave the stream or continue migrating often fall through the cracks.

Impact of Cultural Variations on Care

The third overall theme concerned the special needs of an extremely diverse farmworker population. Farmworkers come from varying ethnic/racial groups, speak various languages, and may have customs that are different from those found in the communities in which they live and work. While some farmworkers were born in the United States and know the language and systems here, others are brought to this country through special labor programs, such as the H2 worker program, or have crossed the borders to work with or without legal documentation. They may speak only their native languages, such as Spanish, Creole, Hmong, Laotian, various indigenous dialects of North and Central America, and others. In addition, farmworkers may have their own beliefs regarding health and illness and have varying approaches to medical practices and healing.

To be effective, HIV prevention for farmworkers must take into account the mosaic of linguistic and cultural patterns seen among farmworkers in addition to differences in familiarity with U.S. systems of health and social services. This presents specific challenges for providers working with the farmworker community.

Photo: U.S. Department of Agriculture

HIV Infection in Farmworking Men and Women

Of interviewed providers, nearly all had reported cases of HIV/AIDS among farmworkers within their state. More individual clinics in the East Coast stream reported HIV/AIDS caseloads of over 35 than did individual clinics in the Midwest and West Coast streams. Respondents in the Midwest stream reported fewer cases than did clinics on either coast.

HIV infection in farmworker women had been seen at almost one-third of the sites responding. Numbers of cases and rates of infection for farmworker women are growing more rapidly with each passing year, paralleling the United States' trend.

The overwhelming majority of respondents cited heterosexual transmission — specifically, intercourse with prostitutes and/or multiple sex partners — as the major factor for contracting the virus. In addition:

- Over half of the providers who cited needle drug use as a transmission factor were from the East Coast stream;
- Twelve providers reported anal intercourse to be the factor by which their HIV-positive client contracted the AIDS virus; and
- Five providers reported mother to fetus transmission/exposure.

Case study: Petra

Petra is a bright Latina woman in her mid-20s who comes from a large farmworking family that had "settled out" of the West Coast migrant stream. Early in her teens she became addicted to IV drugs and used prostitution to help pay for them. She had been hospitalized twice for infections caused by the drug use and was feeling sick again. This time the doctor told her she didn't have an infection but was pregnant. She was terrified that Child Protective Services would take this baby away, as had already happened to her once, so she fled, hiding deep within the community of the streets.

Meanwhile, the tests her doctor ran came back positive for HIV, the first HIV positive pregnant woman to be diagnosed in this small farming community. Outreach workers from the Health District enlisted the help of her family and together they spent weeks looking for her. When she was found she had to be hospitalized for skin infections. There, she found out she was HIV positive.

Petra reacted to the news by announcing she was going to clean up her life. She stayed in the hospital until her daughter was born, then took the baby with her to inpatient treatment. After a 28 day program, she found a home for women and children who were recovering from addiction to alcohol and other drugs and stayed for a year.

Today, she has a healthy T-cell count and has married. Her daughter was declared HIV negative recently. Petra is making presentations to youth groups to encourage them not to use drugs and to educate them about HIV. The availability of outreach workers and drug treatment were critical to her recovery and continued health.

HIV Facilitating Factors and Barriers to Prevention

The survey also asked for providers' perceptions of the extent to which HIV facilitating factors — conditions that increase the risk of HIV transmission — are present among their farmworker clients in general and of the barriers to HIV prevention faced by farmworkers and the professionals who provide services to them.

The most frequently reported facilitating factors for HIV infections were:

- Sexually transmitted diseases (98 percent)
- Alcohol use (88 percent)
- Tuberculosis (69 percent)
- Illicit drug use (38 percent)

According to respondents, farmworkers often live in close quarters with poor sanitary facilities and limited ventilation. Not only do such living conditions lead to the spread of communicable disease such as tuberculosis, but they also create high stress for farmworkers. The association of such stressful living environments with high rates of alcohol use and sexual intercourse with prostitutes and/or multiple sexual partners, particularly among single farmworker men, was described by nearly all respondents.

Related to this, behavioral choices that are the result of learned gender roles were seen to be important facilitating factors for the transmission of HIV. Nearly all providers (90 percent) described patterns of interpersonal relationships between farmworker men and women and definitions of sexuality as being both facilitating factors for HIV and significant barriers to the development and effectiveness of HIV prevention interventions. Roles and behaviors that may serve to hold together a community in a country from which a farmworker comes may not be adaptive in the United States, particularly considering the increased risk of exposure to HIV that may be encountered here.

For example, respondents described how varied the cultural and gender groups to which farmworkers belong are in terms of the acceptability of sexual intercourse outside of marriage or committed relationships, the meaning attached to the use of a condom, the meaning of the term "homosexual," and the sensitivity about frank discussion of sexuality. Because of these wide variations, each group must be specifically targeted during the development of HIV prevention education sessions. However, given overall limited resources, this is a very difficult goal to reach.

Nearly 75 percent of providers also mentioned the following challenges to HIV prevention: lack of transportation, high mobility, and lack of access to any health information at all.

Farmworker Women and HIV

As many as 70 percent of women work in the fields with their husbands or partners. These women also traditionally carry the responsibility for home and child care. Moreover, an estimated 63 percent of the migrant farmworker population consists of children 16 years of age or younger[26]. The illness and eventual death of farmworker women who are vital to both their family's economic status and health and well-being will be devastating to the farmworker community.

Nearly one-third of respondents had seen cases of HIV and/or AIDS among farmworker women. Two cases of AIDS were mentioned among farmworker children. Although the incidence of HIV among farmworker women is presently less than that among men, it is clear that female farmworkers are becoming infected, given the rates of infection and the high prevalence of facilitating factors in the work camps. Unfortunately, many

"Nearly one-third of respondents had seen cases of HIV and/or AIDS among farmworker women."

women do not believe they are at risk and do not or cannot take precautions.

Providers were interviewed regarding the following in farmworker women: 1) HIV facilitating factors, such as substance abuse and tuberculosis; 2) risk behaviors and knowledge of HIV transmission; and 3) attitudes toward HIV prevention among farmworker women.

The following HIV facilitating factors were most frequently reported among farmworker women specifically:

- Sexually transmitted diseases (95 percent)
- Tuberculosis (57 percent)
- Alcohol use (54 percent) (with 65 percent of providers reporting alcohol use being from the Midwest stream)

When asked about commonly held misconceptions regarding HIV among their farmworker women clients, most service providers reported a general lack of understanding of HIV/AIDS, and a belief that the disease would not affect them personally. Nearly every provider interviewed described their clients as holding the belief, "I cannot catch AIDS since I am faithful to my husband." Many added that farmworker women who hold this belief also assume that their husband is being faithful to them. Other commonly cited beliefs included, "AIDS cannot affect families, only gay males," "I can avoid catching AIDS by only being with partners I can tell are clean," and "People catch AIDS by giving blood."

When asked about behaviors in which farmworker women are engaging that may put them at risk for exposure to HIV, providers described farmworker women as lacking the ability to negotiate with their partners to protect themselves. For example, only one in ten providers indicated that their clients are able to ask or insist their partners use condoms, and over two-thirds reported their clients to be routinely unaware of their partners' risks (such as multiple partners or drug use).

Forty-two percent of providers believe that their farmworker women clients are engaging in anal intercourse. Most often this was described as a common practice among young females for birth control. However, other providers believe that few of their clients are engaging in this risk behavior (particularly Hispanic/Latina farmworker women) because it is not a part of their culture.

Clearly, the high level of misinformation regarding personal risk of HIV infection among these at-risk women indicates an acute need for substantial, targeted education programs. A few such programs exist as will be discussed in the next section.

HIV/AIDS Services for Farmworkers

A primary goal of the interview process was to learn more about programs to prevent, diagnose, and treat HIV infection and AIDS among farmworking men, women and children. Providers were asked to describe all HIV/AIDS services available in their areas and the population groups targeted by these services. While HIV prevention education, screening and treatment services are being provided, not surprisingly most of those interviewed said that their efforts are stymied by a lack of funds.

HIV Prevention

Although most respondents (98 percent) reported HIV education programs to be available and 83 percent said that farmworkers were being directly targeted by this education, fewer than 25 percent of such programs specifically target farmworker women.

A clear distinction was made between the availability of and accessibility to these services. In some communities, much is being done to reach out to farmworkers, including presentations in labor camps and other areas where farmworkers gather. In most communities, however, services that are offered to the general community are difficult for farmworkers to access because of their long working hours, transportation barriers, and lack of information about available services. Even in communities where HIV prevention is targeting farmworkers, funding for such outreach is often piecemeal and tenuous.

Photo: South Florida—Alan Poque © 1988

The following HIV prevention education services were reported as available in the respondents' communities:

- Individual counseling (85 percent)
- Street/camp outreach (79 percent)
- Health fairs and other community events (63 percent)
- Small/focus group sessions (60 percent)

Other avenues through which service providers knew of HIV education taking place included local schools, through the migrant education program (27 percent), and church outreach (12 percent).

Innovative means for bringing HIV education to farmworkers included:

- Public service announcements on radio and television
- Workshops for Migrant Head Start parents
- Camp presentations with role playing
- HIV education in STD clinics, homeless shelters, community cultural centers, laundromats, Alcoholics Anonymous meetings, soccer team practices, community movie fests, "smoker's groups," "coffees," and English as a Second Language classes.

While this list is broad, it should be noted that it may not include all outreach and prevention activities from which farmworkers may benefit. For example, the survey was targeted to Migrant Health, Migrant Head Start and Migrant Education Program

Highlight: Yakima, Washington

The Greater Yakima Valley in the State of Washington is an agricultural community of 220,000 people (of which approximately one-third are farmworkers). Farmworker living and working conditions (such as pesticide use) and social problems (such as alcoholism and drug abuse) contribute to major health problems in the county. And, because the migrant stream provides cover for drug trafficking operations, Yakima is considered the "cocaine corridor" of the West Coast.

To address the increasing rate of HIV infection in the community, various health and social service organizations have banded together to create comprehensive education, screening and treatment services for the community as a whole, and migrant and seasonal farmworkers in particular. The People of Color Against AIDS Network (POCAAN) and its community-based outreach workers join with HIV case managers from the Farm Worker's Health Clinic and the local health department to provide education and screening programs on-site in the labor camps on a regular basis. HIV educators present information on HIV and soon will be able to conduct HIV tests on the spot.

A local Spanish language public educational radio station, KDNA Radio, better known as Radio Cadena, provides public service announcements on HIV/AIDS and talk show programs about HIV. One of this station's most successful programs, "Tres Hombres Sin Fronteras," has been broadcast around the country to teach Hispanic/Latino farmworkers about AIDS. HIV education is also being provided in other places where farmworkers gather: churches, homeless shelters, English as a Second Language classes, Alcoholics Anonymous meetings and at soccer practices.

Two nights per week, the New Hope Clinic, a volunteer run HIV/AIDS treatment center, opens its doors to community members. Services include medical, pharmacy, nutrition, case management, touch therapy, legal referral, dental hygiene, and mental health services.

The Yakima Valley has recently experienced its first cases of infants born to HIV infected mothers. In the Yakima area, approximately 15 percent of the HIV/AIDS cases are among women and 20 percent of all HIV infection is transmitted heterosexually. Understanding that women and children have special needs around HIV infection and AIDS, community physicians have developed referral relationships with the closest pediatric HIV specialty clinic, the Northwest Family Center. This clinic has provided special in-service training to local physicians regarding protocols for treating HIV infected children and their families so that children can be treated longer in the community. A pediatric AIDS specialist has also visited the community to treat HIV infected children, and plans are in the works to institutionalize follow-up clinics one to two times per year.

providers, but not to the broader array of programs — including agricultural extension, job training, school programs in general, Red Cross programs or others, which may also provide such programs for farmworkers.

The majority of respondents described their HIV education programs as being "generalized to the farmworker population," meaning that no specific risk group such as men having sex with other men, needle drug users, etc. was targeted in camp presentations. Thirty percent of providers interviewed mentioned teens (in school and out of school) as a target group of their HIV education programs. However, nearly all respondents mentioned the lack of low literacy and/or culturally, linguistically and gender appropriate materials, a factor that makes it difficult to tailor HIV prevention education sessions to specific target audiences among farmworkers.

HIV Screening Services

Ninety percent of interviewed providers reported HIV risk assessment and testing/counseling services available in their community, but only one-third target farmworkers. Of these, fewer than one in five provide specialized services to farmworker women. In many communities, this means that screening services are provided at a local health agency that may or may not have bilingual/bicultural HIV counselors aware of the special needs of farmworkers, and clinic hours may be limited to times when farmworkers must be working in the fields or in places that farmworkers can not access due to lack of transportation.

HIV/AIDS Treatment Services

Medical care for HIV/AIDS is less prevalent in the communities interviewed than are prevention and screening services. Fifteen percent of providers reported no HIV medical care available locally, and farmworker targeted HIV treatment was available in under 50 percent of the communities. Because care often is not available locally, referrals are necessary, often to specialty clinics in metropolitan areas that may be a few hours' drive away. Such distances may create too great a barrier. As many clinic operators know, even for general primary care at local clinics, a lack of transportation is significant enough to prevent farmworkers from seeking nearby treatment. Many providers described a need for targeted HIV/AIDS care training for migrant health providers so that HIV positive farmworker clients could be seen longer at the migrant health center.

HIV/AIDS Social/Financial Support Services

Less than 75 percent of all interviewed providers stated that financial and social support services were available to HIV infected people in general, and less than 30 percent of providers reported these services as being available specifically for farmworkers. As the case studies throughout this report testify, many providers encounter difficulties enrolling HIV positive farmworkers in Medicaid or other forms of medical assistance, particularly if the farmworker is undocumented. Other support programs, such as housing, food services, and pharmacy are even more difficult to access, leaving HIV positive farmworkers without any form of assistance to meet the extreme challenges presented by HIV disease.

Highlight: The Viviremos Project

"Viviremos! On the Road to Healthy Living," a CDC funded project of the National Coalition of Advocates for Students, provides HIV/AIDS education to migrant students in all streams. The curriculum uses games, role plays, and group learning activities to teach the knowledge and skills young people need to avoid HIV infection. The curriculum is on a fourth grade reading level. To date training has taken place in Florida, Washington State, Texas, Pennsylvania, California, and New York.

In Florida, the Health Department, Education Department and Migrant Education Program collaborate to hold annual summer institutes for migrant students. These institutes are held at three universities in Florida in Hillsborough, Broward and Volusia counties. Through the institute, the Viviremos Project has provided a one-day health education curriculum to the 400 enrolled students. The student group "Students Against AIDS and Drugs" provided theatrical presentations on the dangers of HIV. Workshops on cultural sensitivity for teachers attending the Florida Prevention Center's Sexuality Institutes were held. In addition, in June of 1991, in Del Ray Beach, Florida, 35 advocates for adolescent farmworker health were gathered together by the Viviremos Project to draft issues, barriers, and recommendations for adolescent farmworker health.

In Washington State, health conferences were held on comprehensive health issues for 850 migrant parents in three different regions of the state. In addition, 80 migrant education teachers were trained to use the Viviremos curriculum.

In Texas, the Texas Department of Education, in conjunction with the Viviremos HIV Education Project, provided HIV prevention training to teachers, nurses, and school psychologists working with migrant students. Head Start preschool teachers at both the national and state-wide conferences were trained on HIV prevention by Viviremos staff.

In California, migrant education clerks, school nurses, school psychologists, employment agency clerks, and migrant parents have been trained on HIV prevention. Working in conjunction with the Learning Centers of Healthy Kids, Healthy California, regional training of migrant education teachers has been organized for the spring of 1994.

In Pennsylvania, migrant education staff and parents of migrant children have jointly attended HIV prevention education sessions with Viviremos staff. The Viviremos curriculum was adopted statewide by the Department of Education as an HIV curriculum for teachers to use.

Recommendations

A large part of the interview process focused on recommendations for change needed at the local, state, and national levels to address HIV/AIDS among migrant and seasonal farmworkers and their families. Providers were asked specifically for changes needed to improve HIV prevention services, increase the number of farmworkers being screened for HIV, and improve treatment for HIV infected farmworkers and their families. Recommendations having particular relevance to improving HIV services for farmworker women and their families are described below.

Program Development

Data Collection/Research

To more effectively establish national priorities for HIV/AIDS and to specifically address the disease among farmworker families, a data collection system should be established to collect HIV specific data such as seroprevalence rates, knowledge, attitudes, behaviors, and HIV facilitating factors within federal farmworker programs. In addition, other federal programs addressing HIV, maternal and child health, sexually transmitted diseases, and tuberculosis should compile farmworker specific data.

To make these efforts possible, Congress should allocate monies for farmworker specific data collection and research, particularly to the Health Resources and Services Administration, which administers the Migrant and Community Health Center Programs, and to the Centers for Disease Control and Prevention (CDC). Current National Institutes of Health efforts to expand recruitment of under-represented populations in community clinical trials, including farmworkers, should be continued and increased.

Funding

Congress should appropriate additional funds to programs that target farmworker health and HIV/AIDS and encourage coordination between maternal and child health, farmworker, and AIDS programs.

Such coordination should include an interstate transfer system for medical information on HIV infected farmworking men, women, and children.

"To more effectively establish national priorities for HIV/AIDS and to specifically address the disease among farmworker families, a data collection system should be established to collect HIV specific data such as seroprevalence rates, knowledge, attitudes, behaviors, and HIV facilitating factors within federal farmworker programs."

The Secretary of Health and Human Services should establish the prevention and treatment of HIV/AIDS among farmworking women and children as a priority in federal health service programs that target women and children in general and farmworking women and children in particular.

- The Maternal and Child Health Block Grant program should encourage states to develop HIV prevention programs and materials for farmworker women and families;
- The Ryan White CARE Act Title II program should include provisions in its guidelines for consortia to include community-based organizations that work with farmworkers. It should also advise specific set-asides of state funds for HIV testing and drug treatment programs at Migrant and Community Health Centers;
- Ryan White Title III and IV programs should include in their guidances that farmworker service agencies, including Migrant and Community Health Centers, are priority entities for receiving grant monies; and
- The Community and Migrant Health Center programs should include HIV/AIDS prevention and treatment as priority services for centers and clinics.

Photo: National Archives—Arizona—Dorothea Lange, 1940

The CDC should allow for greater input from community-based organizations to the counseling, testing, referral, and partner notification programs and the tuberculosis and sexually transmitted diseases programs and target dollars for development of prevention programs for farmworkers.

Congress should insist that the Department of Education and the Department of Health and Human Services coordinate their efforts and target AIDS education within the Migrant Education and Migrant Head Start programs.

Program Configuration

Community Planning/Needs Assessment/Coordination

Grant requirements for federal HIV/AIDS funding sources underwriting local service agencies such as migrant health clinics, AIDS service organizations, and local

health departments should require joint planning by the separate organizations providing HIV services in an area. Guidances for programs such as the CDC's health department testing funds, the Maternal and Child Health Block Grant, and Ryan White CARE Act funds should include provisions for explicit collaboration such as bi-weekly meetings during the migrant season, signed memoranda of understanding regarding referrals, transportation linkages, locating workers at each others' sites, and other strategies.

However, such guidance within the various federal programs cannot guarantee it will take place or be effective. Therefore, elected officials, agricultural employers (growers), directors of agencies, and other community leaders should become involved and provide support to community coordination and planning efforts. Farmworkers should be included on all service planning boards and extra support for translators should be provided to ensure full representation.

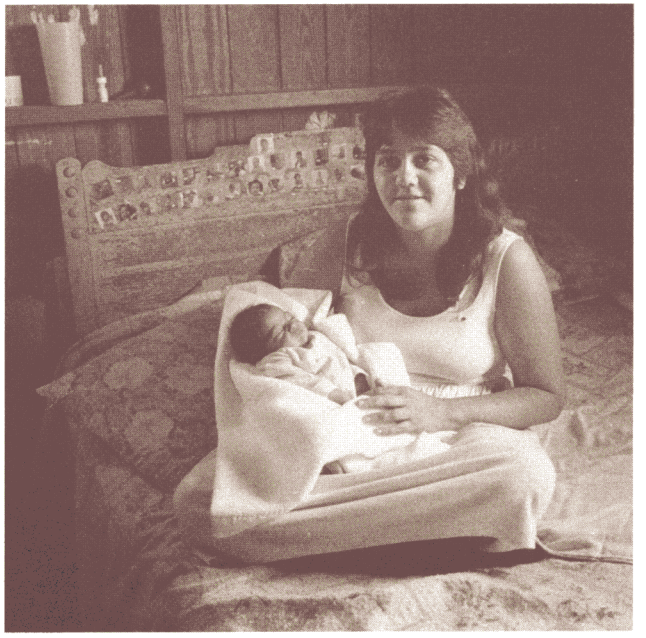

Photo: Alan Poque © 1988

Culturally Appropriate Materials and Intervention Methods

Federal programs such as Migrant Health, Migrant Education and Migrant Head Start should include bilingual/bicultural providers, and use appropriate materials and intervention methods at their service sites. In many locations, funding and recruitment assistance may be needed to accomplish this goal.

State and local programs should also target the needs of farmworkers by providing linguistically, culturally, and gender-appropriate HIV counselors. These include welfare agencies, health departments, hospitals, and AIDS service organizations. To support this, organizations/agencies receiving funds through the CDC's counseling, testing, referral, and partner notification program and the Ryan White CARE Act should be required to document if and how their services address the needs of farmworkers at risk for HIV. However, because design of these programs takes place at the state level, states should establish priorities for hiring bilingual and bicultural providers in areas of high farmworker concentration.

The Secretary of Health and Human Services should develop HIV/AIDS materials for women of various ethnic/racial backgrounds and for farmworkers specifically

"... because achieving good health and access to health care, particularly for high risk populations, requires much more than just an insurance card, all current public health programs, such as migrant health centers and others that serve farmworker families, should be maintained and strengthened as the nation moves to reform the health care system."

through the Maternal and Child Health Block Grant and Community and Migrant Health Center Programs. Aggressive dissemination of the materials through the National Maternal and Child Health Clearinghouse, the National Migrant Resource Program, and other means should take place.

Outreach

Farmworkers face a range of barriers to primary health care in general, let alone HIV prevention education, screening and treatment. Federal and state health programs that target farmworkers and women and children should incorporate outreach strategies for farmworkers.

Such outreach could include:

- use of mobile clinics for HIV/TB/STD screening;
- provision of transportation from labor camps to the clinic on a regular basis;
- use of leaders in the farmworker community as lay health advisors and HIV educators;
- home visiting methods using lay and professional workers;
- provision of HIV prevention education in areas where farmworkers recreate or gather on a regular basis, such as cultural centers, parks, churches, soccer fields, etc; and
- late night clinic hours for farmworker clients.

Health Care Reform

As Congress debates health care reform, provisions should be made to ensure that those who work to harvest our nation's food have access to health insurance and services.

In addition, because achieving good health and access to health care, particularly for high risk populations, requires much more than just an insurance card, all current public health programs, such as migrant health centers and others that serve farmworker families, should be maintained and strengthened as the nation moves to reform the health care system.

Conclusion

Health problems among migrant and seasonal farmworker families are not new phenomena. These families' arduous and dangerous jobs, poor living conditions, transient lifestyles, and low economic, social, and educational status make them inherently vulnerable to a host of maladies. In the same way that it has done in thousands of communities across the country, HIV/AIDS poses one of the most devastating threats that the farmworker population has ever experienced.

Clearly, HIV/AIDS has already infiltrated the migrant and seasonal farmworker community. Although the exact incidence and prevalence rates are not known, a growing number of cases of HIV/AIDS are being identified among an increasingly diverse population of farmworkers. Those surveyed for this report noted that they were seeing more and more HIV/AIDS cases among farmworker men, women and children. Compounding this frightening trend is a paucity of public programs and policies that address prevention, education, and treatment of HIV/AIDS among migrant and seasonal farmworkers.

All too often in the United States, decision-makers and others in the position to affect change fail to act until forced to do so by a problem reaching crisis proportions. That very scenario could play out in the case of HIV/AIDS among farmworker families unless action is taken immediately. It is critical that we, as a nation, commit to making the health and well-being of farmworker families a priority. Acting on the recommendations offered in this report is a critical first step, and one that cannot be delayed.

Photo: Kokomo, Indiana —Alan Poque © 1988

Resources and Materials

CDC National AIDS Hotline
P.O. Box 13827
Research Triangle Park, NC 27709
800/342-2437 English
800/344-7432 Spanish—(7 days/week) 8am-2am EST
800/243-7889 TDD—(Monday-Friday) 10am-10pm EST

This national hotline provides education and referrals to services, as well as free written information. General information on testing, transmission, and treatment options, etc., can be provided over the phone. More specific local information can be obtained through referrals from their large data base. Specialists available 24 hours/day, 7 days/week. They do not have specific information on farmworkers, but they can provide local referrals.

American Red Cross
National HIV/AIDS Headquarters
1750 K Street, NW, 7th Floor
Washington, D.C. 20006
202/973-6000

The national center for Red Cross training and information on HIV/AIDS coordinates four programs: basic training on HIV/AIDS service delivery, prevention information and policy guidelines for workplace issues, African American community issues, and Hispanic community concerns. Call or write for information.

American Indian Health Care Association
245 East 6th Street, Suite 499
St. Paul, MN 55107
612/293-0233

The Association has brochures, posters and a quarterly newsletter. Much of their information addresses Native Americans and HIV/AIDS issues. Contact the Association for resource list and prices.

Association of Retarded Citizens
ARC Research and Program Services
500 East Border Street
Suite 300
Arlington, TX 76010
817/261-6003

ARC's "SAFE Curriculum" (Stopping AIDS through Functional Education) is a detailed curriculum including videos, slides, art work for transparencies, etc. Eighteen one hour lessons, appropriate for low literacy populations. Cost: $75.00.

Comité de Apoyo a Los Trabajadores Agrícolas (CATA)
4 South Delsea Drive
P.O. Box F
Glassboro, NJ 08028
609/881-2507 or 1-800-989-2282

CATA's "El SIDA: Esta Matando a Los Trabajadores Agrícolas y Sus Familias" is a pamphlet that addresses AIDS and farmworkers. Contact CATA for ordering information.

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061-1830
800-321-4407

Publishes and distributes educational information on a wide variety of health-related topics, including HIV/AIDS. Most materials are for children, ages K-12. Materials include brochures, pamphlets, booklets, videos, and classroom curricula. Many are available in both English and Spanish. Contact ETR for price listing.

Haitian Women's Program
465 Dean Street
Brooklyn, NY 11217
718/783-0883, ext. 36-38

Provides education on AIDS and other health topics to the Haitian community. Has brochures on STDs and related topics, including a video in Creole on HIV and Haitian women called "Se Met Ko."

National Association of Community Health Centers
1330 New Hampshire Avenue, N.W.
Suite 122
Washington, D.C. 20036
202/659-8008

Distributes "AIDS and Medicaid: Response to the Challenge. A Guide for Community and Migrant Health Centers and Health Care for the Homeless Grantees." November, 1991.

National Coalition of Advocates for Students
100 Boylston Street, Suite 737
Boston, MA 02116
617/357-8507

NCAS has easy-to-read brochures/booklets to help set up school HIV prevention groups, provide guidelines for student support services, and list criteria for evaluation of AIDS curricula. The *Viviremos Curriculum: On the Road to Healthy Living, a Bilingual Curriculum on AIDS and HIV for Migrant Students (6-12)* and training sessions for this curriculum are also available through NCAS.

National Council of La Raza
810 First Street, N.E.
Suite 300
Washington, D.C. 20002
202/280-1380

Wrote and produced a useful guide entitled, *An Action Plan for Providing HIV/STD/TB and Immunization Services to the Migrant And Seasonal Farmworker Community.*

National Migrant Resource Program
1515 Capitol of Texas Highway South
Suite 220
Austin, TX 78746
512/328-7682

NMRP has texts, brochures, booklets and other materials in English and Spanish that address HIV/AIDS. Includes "Farmworkers and HIV," a binder of information. Some are free, some must be purchased.

Novela Health Education
University of Washington
1001 Broadway, Suite 1000
Seattle, WA 98122
800-677-4799

Produces "fotonovelas" on HIV/AIDS, AIDS prevention, AIDS and family issues, and related health information. Includes "Tres Hombres Sin Fronteras" booklet and tabloid, which sell for $1 and $.55 respectively.

People of Color Against AIDS Network (POCAAN)
5100 Rainier Avenue, South
Seattle, WA 98118
206/721-0852

Distributes low cost materials on HIV/AIDS in many languages including Spanish, Vietnamese, Chinese, Samoan, Khmer, Tagalog, Korean, and Laotian. Materials in comic book, brochure, and "fotonovela" formats.

Planned Parenthood of Hidalgo County
1017 Pecan Blvd.
McAllen, TX 78501
210/686-0585

Conducts HIV counseling and testing in Hidalgo county. Also does education and outreach, especially in the "colonias," that is, the neighborhoods where many farmworkers live. Community women have been trained as "promotoras" (educators) to teach others in the colonias about HIV/AIDS. They have pamphlets, brochures and a video in English and Spanish.

Redlands Christian Migrant Association
219 North First Street
Immokalee, FL 33934
813/657-3362

Distributes "A Staff Manual about AIDS and HIV Infection for Child Care Centers/Un Libro Para Empleadas Sobre El SIDA y La Infección del HIV para Centros de Niños." Send $5.00 check, payable to Redlands Christian Migrant Association.

United Migrant Opportunity Services, Inc. (UMOS)
929 West Mitchell Street
Milwaukee, WI 53204
414/671-5700

Has many materials on migrants and HIV/AIDS. Includes "El SIDA/AIDS: Lo Que Toda Mujer Necesita Saber (What Every Woman Needs to Know About AIDS)." Also has "Midwest Regional Farmworker HIV/STD/TB Prevention Education Consortium Resource Guide and Curriculum for Migrant Farmworkers." Contact UMOS for ordering information and prices.

Washington State Migrant Council
301 North First Street, Suite 1
Sunnyside, WA 98944
509/839-9762

Has many ongoing projects, including the Hispanic Male Health Project, which addresses HIV/AIDS issues. Available materials include videos, cassettes, books and brochures in Spanish and English targeted to youth, farmworkers and other population groups.

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Appendix

Federal Programs for HIV-Related Research, Prevention and Treatment

The Centers for Disease Control and Prevention (CDC) funds state public health HIV counseling and testing programs in addition to some education and surveillance.

The HIV Program supports research, surveillance, and prevention through information, education, and risk reduction programs. Major activities include counseling, testing and partner notification (CTRPN), HIV prevention among high risk populations, special minority initiatives, programs for school and college-aged youth, information campaigns for the general public, and tuberculosis control efforts.

The Tuberculosis Program gives grants to states and large cities for TB surveillance, control, and elimination programs. Funds are used to develop technologies for TB diagnosis, treatment and prevention, provide assistance to upgrade state and local laboratories, run epidemiological investigations, support educational and training activities, and hire outreach workers who provide directly-observed therapy.

The Sexually Transmitted Disease Program supports primary prevention activities, surveillance systems, screening programs, partner notification and counseling, outbreak control, and clinical skills training by awarding grants to state and local health departments and other nonprofit organizations.

Photo: Library of Congress—Arthur Rothstein, 1940

The Health Resources and Services Administration in the Department of Health and Human Services supports programs to provide health services for mothers and children, the medically underserved, the elderly, the homeless, migrant and seasonal farmworkers and disadvantaged minorities. These programs include the **Migrant and Community Health Center Programs** and the **Ryan White CARE Act Programs** that provide grants to cities hardest hit by AIDS for emergency relief, to states for statewide programs and to early intervention care centers. The Ryan White CARE Act includes:

- **Title I** emergency assistance provides grants to metropolitan areas with very high numbers and/or rates of AIDS cases for outpatient and ambulatory health and social support services. In fiscal year 1993, 25 metropolitan areas were eligible to receive formula grants, In 1994, 9 to 10 new areas are expected to be eligible.
- **Title II** comprehensive care programs support formula grants to states for the operation of HIV service delivery consortia in the localities most heavily affected for the provision of home and community-based care, for continuation of insurance coverage for infected persons, and for purchase of pharmaceuticals.
- **Title III-B** early intervention program funds are used for discretionary grants to migrant and community health centers, health care for the homeless grantees, family planning grantees, hemophilia centers and other private non-profit entities that provide comprehensive primary care services to populations at risk of AIDS. Approximately 96,000 HIV positive persons or persons at high risk for HIV-infection are expected to be served in 1993 at 136 sites.
- **Title IV** Pediatric Demonstration Program supports demonstration grants to develop innovative models that foster collaboration between clinical research institutions and community-based medical and social service providers for HIV infected children, pregnant women and their families.

The National Institutes of Health (NIH) conducts basic research on HIV disease including vaccine development, epidemiology, clinical treatments, and prevention interventions related to sexual and addictive behaviors.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for the Substance Abuse Services Block Grant Program and other programs providing prevention, intervention, outpatient and comprehensive residential services to pregnant and post-partum women and their infants.

National Commission to Prevent Infant Mortality

The National Commission to Prevent Infant Mortality was established by Congress in 1987 to create a national strategic plan to reduce infant mortality and morbidity in the United States. The Commission includes Members of Congress, the Secretary of Health and Human Services, the Comptroller General of the United States, representatives of state government, and experts in the field of maternal and child health.

Knowing that many, if not most, of the answers to how to promote the health of mothers and children have existed for decades, the Commission has focused on practical solutions at the federal, state, and local levels for improving the health and well-being of mothers and children rather than creating a new body of research.

In August, 1988, the Commission presented its findings to the President and the Congress in the report entitled, *"Death Before Life: The Tragedy of Infant Mortality."* This report detailed a series of action steps which could be implemented by the public and private sectors.

The National Commission to Prevent Infant Mortality continues its work to create mechanisms for implementation of the recommendations contained in the above report. Current efforts focus on continuing to bring national attention and a strengthened momentum to activities that promote the health and well-being of mothers and children.

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NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

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