In Their Own Words:

Farmworker Access to Health Care in Four California Regions

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Research conducted by
CALIFORNIA INSTITUTE FOR RURAL STUDIES

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The California Endowment & California Program on Access to Care

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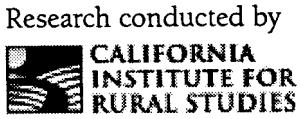

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Authors

In Their Own Words: Farmworker Access to Health Care in Four California Regions is based upon information gathered in the Agricultural Workers Health Study, a research project conducted by the California Institute for Rural Studies beginning in September, 2001. When completed, the research study will have spanned six regions, the first four of which are profiled in this report. The Agricultural Workers Health Study reflects the collective effort of a professional cohort of dedicated researchers, field ethnographers, writers, and editors who have worked in teams to produce lengthy regional case studies. The compilers of this report gratefully recognize the extensive work and time devoted to the project by the following members of the East Coachella Valley, North Orange Belt/Tulare County, North San Diego County, and Oxnard/Santa Clarita Valley research teams:

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Foreword

Since September 2001, researchers at the California Institute for Rural Studies (CIRS) have been investigating the complex interaction between the U.S. health care system and one of the state's most vulnerable populations, immigrant farmworkers. As a leader of efforts to measure the health status of California's immigrant farmworkers, and with more than twenty years of experience in social science research, CIRS was uniquely qualified to take on such a project. In 1999, CIRS conducted the *California Agricultural Workers Health Survey*, a compilation of statistical information on the health status of the state's farmworkers that was released in the November, 2000, report entitled *Suffering in Silence*. Soon thereafter, CIRS researchers undertook a comparative survey of the health status and behavior of agricultural workers in California and their counterparts in sending villages in Mexico, which resulted in the *Binational Farmworker Health Survey*, released in June, 2001. Both of these projects provided ample statistical evidence to demonstrate the poor health of farmworkers, raising many questions about how and why this population does not receive adequate health care.

The desire to inquire further led to development of the *Agricultural Workers Health Study*, a project aimed at examining and explaining the interstices in the relationship between farmworkers and the U.S. health care system. With seed money from the University of California, CIRS then attracted the interest of The California Endowment (TCE), a health care oriented foundation seeking to improve access to care for farmworkers through its *Agricultural Workers Health Initiative*, a funding program designed to support community-based interventions that address this issue.

Seeking solutions in a local context, interviewers/analysts from CIRS focused on six subregional areas of farmworker concentrations that have identifiable groups of farmworkers from known points of origin and settlement patterns and an identifiable community of service providers. Six site-specific reports will be written for TCE, to be used under the auspices of its program.

This report presents the overarching findings of CIRS's *Agricultural Workers Health Study* research conducted in four of the six regions. Its purpose is to share with the public our preliminary observations about the basic problems undermining farmworker well-being and allow for identification of possible approaches by which to ameliorate the situation. This report describes both the obstacles and the opportunities inherent in such a task, in the words of the community stakeholders themselves.


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Introduction

There is growing theoretical and evidentiary literature that demonstrates that Latino immigrants, more than any large demographic group except the homeless, fail to access U.S. health care systems. And among California's Latinos, it is the farmworker population, which consists of at least 700,000 farmworkers and another 700,000 family members in the state at any given time,[1] that faces the most severe barriers. For example, 55 percent of the state's farmworkers earn less than $7,500 annually,[2] qualifying them for benefits such as Medi-Cal. Yet California Institute for Rural Studies' (CIRS's) California Agricultural Workers Health Survey (CAWHS) showed that about 70 percent of this population has no health insurance coverage of any kind.[3] There are many reasons why these people do not participate in the admittedly imperfect social safety net of California's health care systems, including undocumented immigration status, fear of U.S. institutions in general, the complicated application procedures often required, and language and cultural barriers.

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Effective use of health care services is particularly important for farmworkers and their families because of the dangerous nature of their living and working conditions. Their work, in addition to being arduous, exposes them to cancer-causing chemicals and a host of occupational injuries such as falls, puncture wounds, sunstroke, musculoskeletal pain, and stress-related conditions. As a group, they suffer from rates of infection that are higher than that of the general population. They also demonstrate high rates of serious health conditions such as tuberculosis, diabetes, hypertension, and anemia.[4] Situational depression, caused by family separation and poverty coupled with poor living conditions, contributes to unhealthy habits that further put these people at risk.

Economic issues contribute to the difficult life of farmworkers and impede their access to health care. California's agricultural economy has for many decades relied on the immigrant Mexican underclass to constantly supply low-wage workers willing to perform backbreaking labor. The unlimited supply of workers drives down wages and working

[1] Larsen, Migrant and Seasonal Farmworker Enumeration Profiles Study–California.

[2] Rosenberg, et al., Who Works on California Farms?

[3] California Agricultural Workers Health Survey, 1999.

[4] National Center for Farmworker Health, *www.ncfh.org*.

conditions. The predominance in California of the farm labor contractor system serves to blur lines of responsibility on the part of growers for how farmworkers are treated. Particularly now, U.S. concerns about security have resulted in even stricter immigration laws, increased enforcement activities, and an increasingly hostile environment for immigrants, impeding efforts to integrate and assist farmworkers. One example of these tensions is the current debate over whether California institutions should accept *matriculas*, cards issued to Mexican workers by the Mexican consulate, as proper identification.

Politics aside, there are serious consequences for all Californians, in terms of both public health and the economy, for failing to respond to the health care needs of the state's large farmworker population. Identifying effective approaches is a daunting but necessary task, the intricacies of which are not yet fully known. In this report, we take the first step—a thorough investigation of the forces that, within four geographic regions of farmworker communities and their local health care systems, both inhibit and promote health care access and use.

The four regions—northern San Diego County (North San Diego), the Oxnard/Santa Clarita Valley of Ventura County (Oxnard), the north orange belt of Tulare County (North Tulare), and the East Coachella Valley in Riverside County (the ECV)—are geographically diverse. North San Diego and Oxnard are coastal in climate. The ECV is in Southern California's desert region, and North Tulare is in the Central Valley, where most of California's farmworkers live. Among the four areas there is a great variety of climate, farmworker characteristics, predominant crops, and health care systems. Socially and culturally, however, they also exhibit striking parallels. Together, they highlight the kinds of obstacles that farmworkers and their families encounter throughout the state and simultaneously support the value of programs that are designed to fit local needs and conditions.

This inquiry employed a case study approach. Recognizing the fundamental influence of local social, economic, and immigration traits, we used extensive secondary data, such as census information, pesticide maps, official agriculture and employment data, Department of Health Services information, social service and educational administrative data, and various historical and social science sources to inform the study. We placed the farmworker population in a binational context by identifying people's places of origin and exploring some of the health care and economic conditions faced in the hometowns of Mexican immigrants. In addition, we completed a comprehensive study of the health care landscape of the providers of social and health services to farmworkers in each area. This detailed demographic, agronomic, and social situating of the farmworker population informs the place-based, locally relevant approaches we recommend.

We complemented the theoretical framework and secondary data with in-depth open-ended interviews with hundreds of local farmworkers, health care and social service providers, housing officials, county workers, legal aid lawyers, growers, school teachers,

community leaders, and others. Thus, the story was completed through the words of people who actively participate in the sometimes difficult but essential relationship between farmworkers and service providers.

This Report in Context

Health care researchers, using what is known as "theoretical behavioral" models, opened the door to conceptualizing the problem of access to care. Such research explains how certain less fixed, more malleable factors such as attitudes toward disease on the part of patients and attitudes toward clients on the part of providers are more useful in changing behavior than are more fixed characteristics such as occupational status, race, and education. CIRS's research enriches these theoretical insights by expanding the sphere of inhibiting factors to include social isolation; fear of institutions; language barriers, particularly for speakers of indigenous languages; and family separation, all of which are especially important within the context of farmworker families. These factors shape their health care experiences and the environment within which providers must operate.

This report distills the detailed information gathered for each region. Our evidence, while based on a systematic effort to representatively include all of an area's participants, is anecdotal and not intended to be statistically valid. However, we know from our extensive work gathering quantitative data on farmworker health issues that statistics cannot tell the full story. The heartfelt opinions of people directly involved in living this life and navigating the systems provide us with a deeper level of insight.

In the pages that follow, we summarize the demographic, economic, and agronomic conditions of the four areas, followed by a description of the often harsh living and working conditions farmworkers experience. We describe the primary health care problems facing farmworkers in California, the prevalence of those problems, and the challenges encountered in treating them. We delineate the health care landscape available to farmworkers in each region, identifying pervasive barriers to health care as well as facilitators or channels that make health care more accessible. Finally, we present a list of recommendations for program and policy actions that is derived from observations by each community's members.

Throughout the report, we have tried to avoid jargon and overuse of acronyms. For reference, a list of common terms and acronyms is included as Appendix A.

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Main Findings and Highlights

In the following pages, we present a brief sketch of this report, highlighting the main findings of our study and significant features of the study population.

1. **Demographic aspects of the population.**

   a. The areas' farmworkers, who are overwhelmingly Mexican born and raised, include a very high proportion of solo males, nearly half of whom have wives and a quarter of whom have children in Mexico. Women and children, who tend to come after pioneering males get established, represent a large proportion of the community as well. There are few older people, as many immigrants return to Mexico after retirement. Intact nuclear families and solo males present somewhat different service delivery challenges.

   b. Farmworkers are quite poor—median family income is about $7,500 per year (solo males earn less on average). Many live in crowded, unsafe conditions. The majority of farmworkers are people who have settled in California or who regularly travel back and forth between California and Mexico. The median education level is about six years of school.

   c. There is a new and growing group of Mexican farmworkers who speak mainly indigenous languages and have poor Spanish skills. They come from a sector of Mexican society that is impoverished and where they suffered from discrimination by the Spanish-speaking majority.

2. **The four study areas are representative of California farmworker experiences.**

   a. The four study areas encompass the breadth of farmworker experiences in the state. They represent both coastal (Oxnard and North San Diego) and inland (North Tulare and the ECV) areas.

   b. A variety of orchard, row, livestock, and nursery products are represented as well. As a result, the occupational hazards that distinguish these various types of crops are analyzed.

   c. Each region has a unique population comprised of different demographic groups of farmworkers, including solo males, settled families, and migrants who originate from various sending states in Mexico. All of the areas are experiencing an increase in indigenous-language peoples, a population that presents unique health care challenges.

3. **Farmworkers face unique health risks.**

   a. Working and living conditions expose farmworkers disproportionately to respiratory, musculoskeletal, pesticide-related, and infectious ailments.

   b. Despite their relative youth and physical exertion on the job, farmworkers are at risk for chronic conditions associated with relatively high levels of blood pressure, cholesterol, and obesity. Many suffer from inadequate nutrition and aerobic exercise.

   c. Special conditions faced by farmworkers and their families include the scarcity of affordable services and lack of health education, resulting in increased dental and mental health problems.

4. **Health care attitudes based on experiences in Mexico hinder interactions with U.S. institutions**

   a. People from Mexico are familiar with a health care system that involves quick attention, minimal record-keeping, little laboratory testing, and fast-acting

medications. U.S. systems, therefore, engender frustration and distrust from farmworkers. As a result, people tend to self-diagnose, self-medicate, purchase non-prescribed pharmaceuticals, use home remedies, and seek symptom-oriented treatment across the border in Mexico.

b. There is reluctance, especially among men, to seek mental health services despite widespread situational psychological problems such as depression, domestic abuse, and substance abuse.

5. **Immigration experiences impact farmworkers' health and access to care.**

a. Fear of being detected by the Immigration and Naturalization Service hinders mobility and hence efforts to maintain a healthy lifestyle.

b. The undocumented status of many farmworkers discourages them from approaching U.S. institutions because they fear being detected or implicating others by association. Many remain indoors as much as possible, leading to isolationnot only from health care but from social and institutional contacts that could counteract situational depression and other mental health problems.

c. Distrust of U.S. institutions and fears prompt farmworkers to seek health care across the border.

6. **Working conditions and health care access.**

a. Farmworking conditions are worse now than a generation ago. Real wages have declined, there is less subsidized housing, and a higher percentage of farm labor contractors provide the jobs.

b. Despite progress by the Environmental Protection Agency in enforcing pesticide regulations, farmworkers continue to report exposures and poisonings.

c. Despite improvements in sanitation and drinking water, farmworkers perceive that unsafe and unhealthy working conditions persist.

d. Foremen working within the crew-boss system subject farmworkers to work-related abuses that include illegal deductions from pay, charges for rides and drinks, and expecting special favors.

e. Farmworkers experience widespread discrimination, with undocumented workers, indigenous-language speakers, and older workers most often targeted.

7. **Challenges of treating chronic diseases.**

a. Good diabetes care must be continuous, but the many farmworkers who suffer from this condition rarely receive such care. As a consequence, many of them self-medicate, ignore the condition, or seek care outside of the U.S.

b. Obesity, high blood pressure, and high cholesterol, which are associated with chronic diseases, are exacerbated by poor diet and lack of exercise. Inadequate health education resources prevent people from addressing these problems.

c. Infectious diseases thrive among people who suffer from overcrowding, poverty, and limited education. Since the farmworker population is binational, diseases acquired in the U.S. are spread back to home areas in Mexico.

d. Dental problems plague all four communities, and lack of dental insurance coverage and resources prevent many farmworkers from obtaining care.

e. Chronic musculoskeletal pain is very common in this group, but many people neglect care because they cannot pay for it. Often Worker's Compensation benefits cannot be accessed readily by farmworkers.

8. Points of entry to the health care landscape are mixed across areas.

a. The composition of front line service deliverers varies from area to area, and local conditions shape their approaches.

b. The main points of entry are community clinics, free clinics, private for-profit providers, and hospital emergency rooms. These services' effectiveness varies from area to area.

c. The ability of front line clinics to serve farmworkers becomes particularly difficult at the point where a clinic or physician must refer a patient to a specialist.

9. Barriers have critical, negative impacts on farmworker health.

a. Only about 30 percent of active farmworkers have any kind of health insurance beyond Worker's Compensation, and confusion about worker's compensation laws means that many do not receive adequate coverage for job-related health problems. Those on public insurance programs often find it difficult to keep their coverage because of seasonal variations in their incomes and cumbersome paperwork requirements.

b. Farmworkers, especially newcomers and those without a network of connections, often are not aware of the services available to them.

c. Providers are not always aware of services that could help them connect with farmworkers.

d. Language and cultural barriers are enormous. Even when they speak Spanish, providers are often insensitive to Mexicans' ethnospecific conditions and approaches to seeking care. This lack of cultural competence leads farmworkers to lose faith in the services provided. Such barriers are multiplied for indigenous-language speakers, for whom there are very few interpreters and virtually no native-speaking providers.

e. Lack of adequate personal transportation presents a huge obstacle to accessing health care for solo males and families. Farmworker populations are often dispersed in rural and unincorporated areas, and most existing public transportation systems fail to connect farmworker families with services.

f. Inadequate and unsafe housing compromises farmworker health. In addition, many people sublease, share housing, or live in "back of the house" conditions, preventing them from obtaining the documents they need, such as rent receipts, to prove residency and obtain services.

g. Fears related to deportation and possible "public charge" ramifications for relatives if they access services keep farmworkers and their families from taking advantage of the assistance that is available to them.

10. Certain facilitators help farmworkers gain access.

a. Natural social structures, such as binational networks, often help newcomers from a sending area integrate into local U.S. culture and its institutions.

b. The use of promotoras (outreach workers) is rising. They are often effective intermediaries for health education and navigation through care systems.

c. Collaboratives to promote farmworker health are effective at eliminating overlaps in services and appropriately distributing care.

d. Mobile health units are important in bringing care to people who do not readily attend clinics because of isolation, lack of transportation, and financial and safety concerns.

11. Community-based analyses lead to six recommendations.

a. Promote and implement one-stop centers that offer resources for health information and, where necessary, deliver actual health services.

b. Enhance provider and community collaboratives.

c. Improve housing conditions.

d. Recruit and retain culturally competent health care workers.

e. Develop effective outreach to indigenous-language populations.

f. Facilitate greater freedom of movement for health care and recreation through Immigration and Naturalization Service "off limits" policies.

Background

California's Farmworkers

Within California's predominant culture, farmworkers are a poorly understood and often misperceived group. In this section we acquaint the reader with the farmworker population as a whole by providing baseline demographic information that uncovers myths and sheds light on everyday facets of their lives. Much of this information was derived from worker-based surveys, such as the National Agricultural Workers Survey (NAWS), the California Agricultural Workers Health Survey (CAWHS), and the Binational Farmworker Health Survey (BFHS), and from official census and employment data.

How Big is California's Farmworker Population?

The total number of people statewide who do some kind of farmwork in California during the year is estimated at approximately 700,000.[5] The ratio of "peak" to "trough" employment is 1.5 to 1, or about 486,000 farmworkers at peak and about 312,000 at trough.[6] This figure does not include members of farmworker communities who do not do agricultural work, such as spouses and children; they are described later in this section.

Place of Birth, Gender, Age, and Legal Status

Hired farmwork in California is done almost entirely by the immigrant Latino community–95 percent of California's field workers are immigrants and 91 percent were born in Mexico. Many of the remaining 5 percent are U.S.-born children of immigrants.[7]

Recent data show that 82 percent of all California farmworkers are male. This proportion is quite high, and it is increasing because males are more often risking crossing the border without papers now than are women.[8]

California's farmworkers are relatively young. About two-thirds are less than thirty-five years of age and 80 percent are between eighteen and forty-four, with a median age of thirty. Very few are middle aged or elderly; older workers tend to leave the fields for health and other reasons, and many return to Mexico. Only 7 percent of farmworkers are fifty-five or older.

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[5] See, for example, Larsen, Migrant and Seasonal Farmworker Enumeration Profile Study–California.

[6] Employment Development Department, Statistical Division, Sacramento, California, 2000.

[7] Rosenberg, et al., Who Works on California Farms?

[8] Immigration and Naturalization Service statistics show that the percentage of females and children detained at the border fell after 1995's toughening of border enforcement.

The most recently available data (1994–1997) suggest that 42 percent of all California farmworkers do not have work authorizations, and the proportion of undocumented workers has been steadily increasing since passage of the Immigration Reform and Control Act of 1986.[9] Undocumented workers represent the youngest subgroup within the farm labor force at an average age of twenty-five. A NAWS analysis revealed that 88 percent of undocumented farm laborers are younger than thirty-four.

Who Lives in Farmworker Communities?

A phenomenon related to the high proportion of men active in farmwork is the large number of solo males–men who have no accompanying spouse, child, or parent. Solo males comprise 63 percent of male farmworkers and about half of all California farmworkers. These males are not necessarily single or migrant; nearly half are married and nearly half of the married men have children who live in Mexico. There is a trend of family reunification over time. After some time in the U.S., solo males eventually bring their wives and children to California. By inference, therefore, the children of currently solo males can be expected to appear as California residents in the future.

Farmworker communities also include ex-farmworkers and spouses and children of active farmworkers, all of which comprise the farmworker community.

Ex-farmworkers: There is constant heavy turnover of workers involved in agricultural labor, and many farmworkers move on to jobs in other sectors, especially light manufacturing, food processing, construction, and the service trades. It is impossible to estimate the proportion of these individuals in communities. It varies from region to region based on local demand for non-farm labor. It is observed, however, that many of these ex-farmworkers remain in farmworker communities across the state.

Spouses and Children: Children living with their farmworker parents in California are predominantly citizens since two-thirds of them were born north of the border. Surveys estimate an average of one resident child per employed farmworker. About half of farmworkers are parents and about half of them have children living with them in the U.S. In addition, about one-quarter of farmworkers live with a spouse. This means that, in addition to the total of about 700,000 farmworkers in the state, there is an even larger number of family members.

Photo © Bill Gillette

[9] Rosenberg, et al., Who Works on California Farms?

The demographic distribution in farmworker communities is characterized by a group of "anchor" families–both settled and migrant–and by groups of solo males that are usually associated with anchor families by kinship or place of origin. Anchor families with children are predominantly young couples with a median of two children. The two groups, families and solo males, have distinctly different social service needs.

Migration Patterns and Time Allocation during the Year

Common misperceptions about living and migration patterns of farmworkers impact how services are delivered to this varied population. Contrary to the stereotype, farmworkers do not predominantly follow crops. Rather, their living patterns can be broken down roughly into four distinct groups.

Follow the Crop Migrant Workers: This type of farmworker travels between two or more U.S. farm jobs during the farm labor season. These individuals may consider their permanent residences as being in Mexico or as one of their living sites in the U.S.[10] Most people think of this pattern of migration as common, but only about 10 percent of farmworkers follow this pattern, and they are mostly solo males.

Shuttle Migrants: About one-fifth of farmworkers can be classified as shuttle migrants who travel back and forth between Mexico and California. Shuttle migrants live part of the year in their hometowns in Mexico (some live in Texas) and migrate to a single area in California for the farm season. This group is composed of both families and solo males. In recent years, shuttling has generally declined and it is now done more by legal immigrants since the border has become difficult and expensive to cross without papers. These migrants reside in one place in California and commute to work sites.

Newcomers: Approximately one-sixth of farmworkers are newcomers or first-year immigrants (mostly solo males). This group has been expanding in recent years as a proportion of the total.

Settled Farmworkers: About one-half of all farmworkers are year-round, settled California residents who live and work in the same region throughout the year.

Both settled farmworkers and shuttle migrants, a combined total of three-quarters of California's farm labor force, are committed to their particular communities in California, remaining or returning there year after year.

Another informative distinction is the number of years of experience the population has doing farmwork. About 55 percent of the state's farmworkers have worked fewer than nine years and 34 percent have worked four years or less. About 45 percent have worked ten years or more.

These figures, along with the high percentage of first-year newcomers (overwhelmingly young Mexican immigrants), demonstrate that farmwork is an occupation characterized by high rates of turnover. There is a core group of people who learn to make a long-term

[10] Mines and Gabbard, Migrant Farmworkers: Pursuing Security in an Unstable Labor Market

living as farmworkers. The ones who cannot are continuously replaced by the annual influx of newcomers looking for employment in the U.S.

Income, Wages, and Poverty

According to NAWS data for 1994–1997, the average wage for farmwork was $5.69 per hour, or just above minimum. In addition, the seasonal rise and fall of agricultural work makes it difficult for laborers to maintain steady incomes. Most farmworkers do not find continuous work through the year; just twenty-six weeks represent the median per year, leaving households with very meager incomes. Information from the NAWS indicates that three-quarters of farmworkers earn an annual income of less than $10,000, and at least 61 percent of all California farmworker households fall below the poverty line.[11]

The financial hardship endured by farmworkers is exacerbated by severe working conditions. The labor market is organized on a crew system in which workers are hired, supervised, and terminated by foremen. These crew bosses often take illegal deductions from paychecks and charge workers for rides, drinks, and tools, the latter practice being illegal in California for those earning less than twice the minimum wage. (The farm labor contractor system is described in more detail later under *Working Conditions*.) In addition, many farmworkers cash their paychecks at check-cashing stores that charge a fee for the service, further reducing the amount of their take-home pay.

According to the NAWS, most farmworkers (77 percent) live in apartments or small houses not owned by their employers and only about 5 percent live in employer-provided housing. A minority live in small houses and trailers they have purchased. It is important to note here that many farmworkers live in extremely substandard situations, including converted garages, sheds, and stick-built houses. Others are homeless and live in cars, holes in the ground, and fields, sleeping under sheets of plastic. See *Farmworker Living Conditions* for detailed information on this and other aspects of farmworker life.

Medical Insurance and Other Protections

The farmworker population receives few protections or benefits. Though estimates of the proportion of insured farmworkers vary from survey to survey, it is clear that the farmworker population is largely uninsured. According to the NAWS, only 5 percent have off-the-job employer-paid health insurance, though 90 percent of respondents noted being protected by Worker's Compensation.[12] In CIRS's CAWHS, 70 percent of the adult farmworker respondents described being uninsured; in the BFHS, which included ex-farmworkers, 58 percent indicated that they had no insurance.[13]

[11] Rosenberg, et al., Who Works on California Farms?

[12] Ibid.

[13] One-third of respondents in the BFHS were older, established ex-farmworkers, and it is arguable that they had closer ties to services and social support systems.

According to NAWS data, 41 percent collect some unemployment insurance during an average year but only 14 percent receive Women Infants and Children (WIC) assistance and 6 percent receive food stamps. A small percentage receives benefits from the other public programs.[14]

As previously noted, children reside in approximately one-quarter of the state's farmworker households. Many of those children are insured under a variety of state and federal programs.

Table 1. Distribution of Farmworkers by Area of California

No. of Farmworkers	Percent	Area and Associated Counties
416,000	55.9%	San Joaquin Valley Kern, Kings, Tulare, Fresno, Madera, Merced, San Joaquin, Stanislaus
143,000	19.2%	Central Coast Ventura, Santa Barbara, San Luis Obispo, Monterey, Santa Cruz, San Benito
62,000	8.3%	Sacramento Valley Shasta, Tehama, Butte, Colusa, Sutter, Yuba, Yolo, Sacramento, Solano
54,000	7.3%	Desert Riverside, San Bernardino, Imperial
35,000	4.7%	Southern California Los Angeles, Orange, San Diego
34,000	4.6%	North Coast Napa, Sonoma, Mendocino, Contra Costa, Lake

Source: California NAWS Data 1995–1999.

[14] Rosenberg, et al., Who Works on California Farms?

Distribution of Farmworkers in California

As indicated in Table 1, the two primary farmworker areas in California are the San Joaquin Valley and the Central Coast, followed by the desert areas and the Sacramento Valley, and then by the North Coast and Southern California.

Binational Perspective: Where are Farmworkers From?

Table 2 clearly demonstrates that most farmworkers originate from just a few states in Mexico. In fact, three-fifths come from just three states–Michoacan, Guanajuato, and Jalisco. It is also common for people to come to the U.S. after first moving from other parts of Mexico to Baja California and Sinaloa. However, states in the traditional Center West–Michoacan, Guanajuato, Jalisco, Zacatecas, Nayarit, and Guerrero–represent 73 percent of the state's immigrant farmworkers.

It is possible to identify with considerable precision the actual towns and villages that typically supply California farmworkers. This creates the opportunity for greater coordination between health programs in sending areas and communities in the U.S.

Table 2. Place of Origin of California Farmworkers

Michoacan	28.7%
Guanajuato	20.3%
Jalisco	12.9%
Baja California	4.9%
Guerrero	4.6%
Sinaloa	4.1%
Oaxaca	3.9%
Zacatecas	3.8%
Nayarit	2.6%
Other	14.2%

Source: California NAWS data 1995–1999.

Overview of Farmworker Health Status

Despite the fact that the majority of farmworkers are relatively young, evidence reveals that these individuals are disproportionately ill or at risk of health problems. Research shows that the frequency and/or intensity of particular health problems is greater within the farmworker population than among Hispanics and the general population. While the health problems described in this section are not unique to farmworkers, hardships in the lives of these immigrants compound the physical impacts of health conditions.

Occupational, Demographic, and Other Factors Influencing Farmworker Health

- Some farmworkers do not have a permanent place to live and routinely migrate in search of work. Those who do have housing often live in overcrowded and deplorable conditions.
- Dermatitis and respiratory problems caused by fungi, water, dust, noxious plants, and pesticides in fields and orchards are common.
- Farmworkers are exposed to numerous toxic chemicals, many of which have been explicitly linked to particular illnesses such as cancer.
- A lack of safe drinking water, both at work and at home, contributes to cases of dehydration and heat stroke.
- An absence of proper sanitation and toilet facilities leads to urine retention, which is in turn linked to urinary tract infections.
- Farmworkers suffer infections more often than the general population.[15] Although field sanitation guidelines have been developed by the Occupational Health and Safety Administration, the guidelines are not always followed or enforced.
- Conditions such as tuberculosis, diabetes, cancer, and HIV, which require careful monitoring and frequent treatment, often go undiagnosed and, when diagnosed, are not treated.
- The incidence of hypertension is significantly associated with working conditions. Epidemiological studies support the view that psychosocial stress contributes to changes in blood pressure and that employment security and other working conditions play a pivotal role. The absence of decision-making latitude on the job, something commonly experienced by farmworkers, has been directly associated with risks for cardiovascular disease and elevated blood pressure.[16]
- As a predominantly Hispanic population, farmworkers are particularly vulnerable to diabetes.

[15] National Center for Farmworker Health, *www.ncfh.org.*

[16] Ibid.

- Depression and other mental health problems, often related to isolation, family separation, and economic hardships, are common among adults.
- Farmworkers lack access to health care, in part due to their lack of insurance.
- Farmworkers lack transportation to clinics and, since they don't receive sick leave, often fear losing wages and even jobs if they take time off for health care.
- Poor dental health among farmworkers is related to lack of hygienic practices, lack of insurance coverage, inability to pay for care, unreliable transportation, and the limited number of providers in some areas.

Looking at Health Risk Factors

CIRS researchers gained dramatic insight into the health of California's farmworker population during the 1999 CAWHS.[17] Based on physical examination data, four risk factors studied in the CAWHS report–high blood pressure, high serum cholesterol, high glucose levels, and obesity–predisposed people to illness and were major contributors to eventual development of diabetes and coronary heart disease. More than one-fifth of male farmworkers have two or more of these three risk factors.[18]

Primary Medical Conditions

Based on an analysis of CAWHS data and other supporting evidence, we identified the following major health problems commonly faced by farmworkers.

Obesity/Body Mass Index:[19] Among CAWHS participants, 81 percent of men and 76 percent of women were overweight. More alarming is the fact that 28 percent of men and 37 percent of women in the sample were considered obese. In the U.S. adult population as a whole, just 20 percent of men and 25 percent of women are obese.[20] Only 18 percent of men and 21 percent of women in the CAWHS sample were noted as having "healthful weight." The remaining 1 percent of men and 2.5 percent of women were found to be underweight. Thus, two-fifths more farmworker men and a slightly greater percent of women in the CAWHS sample were obese compared to U.S. adults.[21]

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[17] The 1999 CAWHS used a household sample of 971 farmworkers from seven randomly selected farmworker towns in California. The towns represented the six agricultural regions of California. Physical examinations and complete blood counts (CBCs) and blood chemistry data were gathered from 652 of the participants. The CAWHS also posed questions regarding demographic characteristics, employment experiences, and health outcomes in the farmworker population. Funding for the study was provided by The California Endowment.

[18] The study also included breast and cervical cancer screenings of farmworker women wherein 7 and 13 percent, respectively, of the tests yielded abnormal results.

[19] The Body Mass Index (BMI) is an indicator of healthy body weight. It is defined as a person's weight in kilograms divided height. People with a BMI of 30 or higher are considered obese.

[20] Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES). Comparisons of CAWHS subjects were made with NHANES 1988–94, the most contemporary data available during the CAWHS study.

[21] Ibid.

Cholesterol:[22] In each age cohort studied (20–34 years, 35–44 years, and 45–54 years), male farmworker subjects showed a rate of high serum cholesterol that exceeded that of U.S. adults. The fraction of female subjects showing high serum cholesterol was found to be significantly below the average for U.S. adults.

Blood Pressure:[23] In the CAWHS sample, it was observed that 7.2 percent of all subjects had high systolic pressure and 4.7 percent had high diastolic pressure. The survey also estimated that 8.5 percent of all farmworkers in the sample had either systolic blood pressure of over 140 mmHg or diastolic blood pressure greater than 90 mmHg.

Dental Problems: While the prevalence of dental decay has declined significantly over the past two decades for the general U.S. population thanks to preventive practices that improve oral hygiene, the same cannot be said for the farmworker population. According to an analysis of data from migrant health center encounters, dental disease ranks as one of the top five health problems for farmworker family members between five and twenty-nine years of age and remains among the top twenty for farmworkers of all other ages presenting for care.[24] Primary dental problems include broken teeth, loose teeth, complaints of toothaches that sometimes last months, difficulty eating, decay, and cavities.

In addition, farmworker children experience a rate of dental decay that is twice that of children in the general population.[25] These findings were further supplemented by the results from CAWHS physical exams. In a clinical assessment of 652 adult farmworkers, 30 percent of males and 37.5 percent of females presented with missing or broken teeth at the time of their physical examinations. Gingivitis was the third major dental problem, affecting 14.4 percent of all subjects.

Mental Health: The agricultural system has provoked an enormous turnover in population over the last century in California. Ethnic replacement is a concept used by Zabin et al. (1993) to describe the process by which agricultural employers in California have relied on the sequential entry of groups of foreign workers for most of the last hundred years. Generally speaking, more settled groups of farmworkers are replaced by new ones

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[22] Cholesterol is a blood lipid, a fatty substance found in all parts of the body. Cholesterol is measured based on its concentration in the blood stream A total cholesterol level of under 200 mg/dl is desirable, as levels in this range are associated with the least risk of heart disease. The CAWHS considered high serum cholesterol to be 240 mg/dl or greater from non-fasting samples. The desirable range for adults is 125–200 mg/dl and "borderline" is 200–239 mg/dl.

[23] Blood pressure is the force that circulating blood exerts on the walls of arteries. Its measurement is shown as two numbers—systolic pressure as the heart beats (pressure during contraction of the heart) and diastolic pressure between heartbeats (pressure during the relaxation phase). For the CAWHS, a minimum systolic blood pressure of 140 mmHg and a minimum diastolic blood pressure of 90 mmHg were used as indicators of high blood pressure. The sample size for the analysis of systolic and diastolic blood pressure was 638.

[24] Lombardi, Dental/Oral Health Services.

[25] Koday, et al., Dental Decay Rates among Children of Migrant Workers in Yakima, Washington.

willing to accept lower pay and more difficult working conditions.[26] This cycle traps workers in low paying jobs and unhealthy work environments, relegating many to an impoverished life of struggling for very basic necessities of survival. This experience leads to mental health problems that are exacerbated by additional factors, such as separation from family, physical ailments, and social problems like domestic violence and drug and alcohol abuse.

Substance Abuse: Substance abuse can result when people facing poverty, stress, hindered mobility, and lack of recreational opportunities seek an escape from such troubles. The BFHS revealed that, of 467 farmworkers originating from the Mexican state of Zacatecas, two-thirds indicated that they drink alcohol–74 percent of men and 11 percent of women. Among those who reported alcohol consumption, median use was two days a week, three drinks per sitting. Approximately 13 percent responded that they drink six or seven days a week, with an average of twenty-one drinks weekly.

Pesticide Poisoning: Anecdotal reports from clinicians indicate that many cases of pesticide poisoning are not reported because people do not seek treatment or are misdiagnosed. The symptoms of pesticide poisoning can resemble those of a viral infection or an allergy.

Diabetes: While farmworker-specific data on diabetes are not widely available, background data on Hispanic Americans serve as a proxy. National Diabetes Information Clearinghouse (NDIC) data on diabetes in Hispanic Americans identifies the disease among 25 percent of Mexican Americans and Puerto Ricans age forty-five and older.[27] This rate is two to three times higher than that of non-Hispanic whites.[28] Hispanic women are more likely to have diabetes than are Hispanic men. Risk factors for diabetes include a family history of diabetes, gestational diabetes, impaired glucose tolerance, hyperinsulinemia and insulin resistance, obesity, and physical inactivity.[29] Again, these risk factors are more prevalent in Hispanics than among non-Hispanic whites. In addition, Mexican American diabetics have been shown to suffer higher rates of all complications stemming from diabetes with the exception of myocardial infarctions when compared to non-Hispanic white diabetics.[30]

It is highly likely that migrant farmworkers, the vast majority of whom are Mexican Nationals, experience even greater rates of disease complications due to occupational,

[26] Mines, Family Settlement and Technological Change in Labour-Intensive Agriculture.

[27] U.S. Dept. of Health and Human Services, National Institutes of Diabetes and Digestive and Kidney Diseases, NDIC. This prevalence rate is based on population-based studies utilizing the NHANES III study (1988–94) and the HHANES study (1982–84) to determine the prevalence of diabetes among subgroups of Hispanic Americans.

[28] *www.migrantclinician.org.*

[29] U.S. Dept. of Health and Human Services, National Institutes of Diabetes and Digestive and Kidney Diseases, NDIC.

[30] Migrant Clinician's Network, Diabetes: Addressing a Chronic Disease in a Mobile Population.

socioeconomic, cultural, and political factors.[31] A recent survey (summer 2000) of farmworkers in Michigan determined that 25 percent of those adults over age twenty had diabetes.[32] A Pennsylvania survey found a family history for diabetes in 50 percent of the one hundred farmworkers interviewed.[33] This is consistent with NDIC data.

Tuberculosis: Tuberculosis is usually not as infectious as some other communicable diseases such as measles, but infectiousness varies considerably from case to case. People who repeatedly share the same air with an infected person can be infected.[34] Many farmworkers enter this country from areas of the world where tuberculosis rates are much higher than in the U.S., such as Latin America, Southeast Asia, and Haiti. In addition, crowded living conditions are believed to contribute to the spread of tuberculosis among this population.[35] Diagnosing and treating tuberculosis in migrant farmworkers poses unique problems related to the need for long-term treatment and preventive efforts, difficulties in maintaining compliance, the need for contact examinations, population mobility, fear of deportation, the expense of treatment, and other barriers to health care.[36]

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[31] Migrant Clinician's Network, Diabetes: Addressing a Chronic Disease in a Mobile Population.

[32] Ibid.

[33] Keystone Health Center Report, February, 2001.

[34] The tuberculosis organism is transmitted primarily through the air on small airborne droplets that are produced when persons with tuberculosis of the lungs or larynx sneeze, cough, or speak, according to Centers for Disease Control in Tuberculosis and Migrant Farmworkers, Austin, National Migrant Referral Project, June, 1985.

[35] Wingo, et al., Tuberculosis among Migrant Farmworkers, Virginia.

[36] Ibid.

Demographic Patterns in the Four Study Areas

In designing the Agricultural Workers Health Study, we selected distinct subregions displaying different demographic and agricultural characteristics. For instance, the four regions described in this report vary with regard to the geographic concentration of farmworker populations relative to the larger community. Some are isolated; others are near or intermingled within urban areas. Much of the farm land in Oxnard and North San Diego is near large population centers. In the ECV and North Tulare, small towns predominate. Two of the regions–the ECV and North San Diego–are within easy commuting distance of Mexico. Migration patterns and places of origin vary across the regions. In addition, all four have substantial indigenous-language populations. Across California, Mixteco speakers represent the largest indigenous-language group.

Photo © Jim Bratcher

With regard to agriculture, the four regions differ in climate and geography, creating conditions for different crop and livestock mixes and exposing farmworkers in each area to somewhat different risks. Oxnard and North San Diego are coastal; North Tulare and the ECV are interior regions, which have considerably warmer climates and therefore present greater risks to workers of heat exhaustion and sunstroke. In the ECV, temperatures rise to 120 degrees, and temperatures exceeding 100 degrees are common in North Tulare. The coastal areas have more nursery work, which exposes workers to chemicals in confined spaces. Row and ladder crops involve physically demanding work with a high risk of injuries. The distribution of these crops varies from area to area.

The following describes in more detail the demographic and agricultural patterns of each of the four areas studied.

The ECV

The ECV has a population of about 100,000. The town of Coachella, with a population of about 22,000, is the only incorporated city in the area. Farmworkers are concentrated in a triangle of unincorporated areas just east and south of Coachella called Mecca, Thermal,

and Oasis. According to census data, per capita incomes are below $7,000 in the ECV, and since the census inevitably misses many of the poorest residents in an area, real income levels in the ECV undoubtedly fall far below that figure.[37]

Insight into the Demographics of an Unincorporated Farmworker Town

Despite its limitations, U.S. census information, carefully analyzed, can offer insight into who typically lives in farmworker communities. Most census data do not cover farmworkers in isolated areas; those individuals are mixed in with other populations. CIRS analyzed data for the town of Mecca, which is composed almost entirely of farmworkers and former farmworkers. The data reveal certain demographic patterns about the ECV relative to other parts of the Coachella Valley and the state. Few people in Mecca live alone (about 5 percent compared to 24 percent statewide). Average household size is high (five in Mecca compared to three statewide). The population is also quite young on average (median age in Mecca is twenty-two compared to thirty-three statewide). Fewer than 5 percent are over sixty-five years of age compared to 10 percent for the same category statewide. The proportion of married couples in the population is high (68 percent of households in Mecca compared to 51 percent statewide). There are also many solo males, revealed by the estimated number of females in Mecca (43 percent in Mecca compared to 50 percent statewide). Over 95 percent of the residents of the area are Hispanic.[1] In sum, this group of farmworkers is a young, Mexican immigrant population made up of solo males, many of whom have families in Mexico, and young families. Most live crowded together with many people in a household, and many retired people have returned to Mexico. The census probably understates the number of solo males in Mecca but still paints a believable picture of what the farmworker population there looks like.

[1] County of Riverside Economic Development Administration, U.S. Census Data, 1990.

Throughout the ECV, the population is almost entirely Hispanic, typified by Coachella at 97 percent. Because official data sources do not break out just the ECV portion of Riverside County, estimates of the number of farmworkers in that region vary widely. However, the best estimates put the summer low point at about 5,000 farmworkers employed and the peak at about 9,000. The number of farmworkers employed at some time during the year is about 13,000.[38]

There is an enormous influx of workers into the area in March for the table grape harvest. In general, migration patterns show an influx into Coachella in the spring, with large numbers of first-time immigrants and shuttle migrants from Mexico arriving then. A group of longtime table grape workers begins the year in Coachella and moves north to the San Joaquin Valley for the summer.

According to farmworker informants, the ECV's long settled population of farmworkers and their dependents come mostly from an area in western Michoacan (Jaripo, Juiquilpan) and from the neighboring area of Jalisco near Lake Chapala. In addition, a

[37] Eastern Riverside County Health Assessment, 2000. In contrast, per capita incomes on the central and west side of the Coachella Valley, in towns like Palm Springs, Palm Desert, and Indian Wells, are typically above $40,000.

[38] Irrigated areas in the ECV comprise about 60,000 acres, or about 28 percent of the total in Riverside County. Given an estimate of a peak of about 31,000 workers and a low of about 16,000 countywide, we extrapolated the approximate numbers in the region. The ratio of year-round workers to peak workers is about 1.4 in state estimates.

number of them come from Mexicali and its surrounding areas. A newer but populous group is the Purépecha-speaking people from the mountains of central western Michoacan. Many other parts of Mexico are represented in the ECV in smaller numbers. Every farmworker who participated in our study was either from Mexico or the child of a Mexican.

North Tulare

Tulare County has a much larger farm area than the other three subregions, and its economy is predominantly agricultural. In 2001, Tulare County had the largest agricultural value of any county in the U.S. The Migrant Enumeration Profile Project estimates that there are about 57,000 farmworkers in the county as a whole. However, given the county's widespread agricultural base, it is difficult to establish the number of workers in the study region.

Scattered across the North Tulare region are numerous small unincorporated towns, ranging from several hundred to less than 10,000 residents each, where many farmworkers live and work. The study area includes two small cities, Dinuba (approximately 17,000 residents) and Woodlake (about 6,700 residents). Residents of these towns are predominantly Hispanic–the census identified more than 70 percent in general and in excess of 95 percent in the town of Cutler. The actual percentage of Hispanics is probably much higher. The population variation from month to month is high in Tulare County. Demand for workers varies from 27,000 people in March to 42,000 in June. This variation may be somewhat smaller in citrus growing areas where the orange crop creates employment for about ten months a year for some workers there.

Most of the North Tulare farmworker population comes from the traditional sending states of Michoacan, Guanajuato, Jalisco, and Zacatecas. There is, however, a growing Oaxacan and particularly Mixtec presence in Farmersville in central Tulare County. The census data for all the major towns mentioned above except Cutler show fairly even percentages of men and women over eighteen, indicating a mature and stable settlement pattern. Cutler, on the other hand, is similar to Mecca in the ECV; only 5 percent of the population lives alone, 63 percent of households are married-couple families, 96 percent are Hispanic, 57 percent of adults over eighteen are men, and only 5 percent are over sixty-five.[39]

CIRS interviews confirm the traditional pattern of migration by some North Tulare farmworkers to the deciduous fruit harvest further north in California and into Oregon and Washington. There are also many legal shuttle migrants who spend part of the year in their hometowns in Mexico and the other part in Tulare County.

[39] U.S. Census, Profile of General Demographics, 2000.

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North San Diego

In North San Diego, farmworkers are ensconced in a relatively densely populated, non-immigrant and non-farmworker urban population. Hispanics are a minority in all of the towns in North San Diego. The number of agricultural laborers in North San Diego is difficult to determine and varies during the year. In addition, the large number of workers living in encampments, in fields, and in hidden back houses leads to especially severe undercounting of this group by the census. The Migrant Enumeration Profile Project placed the number at 15,371.[40] The California Employment Development Department shows that countywide employment levels vary from a low of about 9,400 in January to a high of about 11,200 in July, an unusually small variation for a California farm county. Much of San Diego County's agricultural production has shifted to the northern part of the county, so the numbers reflect in large part the workers of the study region.

U.S. census data indicate that the proportion of Mexicans among Hispanics in all the towns of North San Diego exceeds 90 percent.[41] These farmworkers hail from numerous locations throughout Mexico—Queretaro, Guerrero, Jalisco, Morelos, Michoacan, and Zacatecas—with increasing numbers of indigenous-language peoples from Oaxaca.

Photo © David Bacon, dbacon@igc.org

Many North San Diego farmworkers are unaccompanied solo males, both single and married, who vary widely in age. The majority of them are undocumented. Unmarried solo males are generally younger, though most are over eighteen. Married solo male farmworkers' families generally reside in rural Mexico and depend on the monthly checks these men send. In addition, there are significant numbers of settled farmworkers in the region; they are predominantly documented and live here with their families. In many cases, they own a house or trailer and can afford electricity, water, and other basic services.

The Mexican immigrant labor force in North San Diego finds itself in a peculiar situation where movement is sharply restricted due to the border to the south and the presence of Immigration and Naturalization Service (INS) checkpoints to the north. Informants provided anecdotal evidence that undocumented farmworkers, who are clearly the majority, tend not to migrate to other work areas and return only occasionally to Mexico. This lack of freedom of movement limits people's options and therefore undoubtedly depresses wages and working conditions relative to other parts of California.

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[40] Larson, Migrant and Seasonal Farmworker Enumeration Profiles Study–California.

[41] All CIRS farmworker interviewees were of Mexican origin.

Oxnard

In Ventura County, the location of the Oxnard study region, farmworkers live in less concentrated communities. Ventura County's total population in 2001 has been estimated at 763,586.[42] Estimates of the percentage of Latinos included in that figure vary, with census data listing the proportion of Hispanics or Latinos in the city of Oxnard at 66 percent.[43] The number of Latinos in the city of Oxnard has been increasing steadily since the 1970s, and current local estimates put the proportion at 80 percent or higher.

The Migrant Enumeration Profile Project estimates that there are 27,423 farmworkers in Ventura County.[44] Employment estimates show the number of employed farmworkers ranging from about 17,000 in September to about 25,000 in April. The total number of people who do farmwork in the region is greater than the peak figure but is not precisely known. Fairly low seasonal differences in the area imply a somewhat settled, year-round population with a smaller percentage of transients.

To identify farmworker towns in the region, we used criteria in census data. The 2000 census estimated the median age of residents of Ventura County to be thirty-four years. The median age of residents in Santa Paula, Fillmore, and the city of Oxnard are younger, twenty-nine, while Camarillo and Ojai reflect a higher median age of about forty. The cities that have lower median ages are largely Hispanic (more than 65 percent in Santa Paula, Fillmore, and Oxnard); in Ojai and Camarillo, the Hispanic population constitutes approximately 15 percent of the population.

Census data about these farmworker towns also indicate that people in the study region tend to live together in shared housing. While statewide about 24 percent of people live alone, Ventura County shows markedly smaller numbers–19 percent for the county as a whole, 17 percent in Santa Paula, 16 percent in Fillmore, and just 14 percent in Oxnard.[45]

Over 90 percent of the farmworkers in Ventura County are of Mexican origin.[46] The largest networks are from Michoacan, Oaxaca, and Guanajuato. The number of Mixtecs migrating from Oaxaca to Ventura has surged in recent years. Local observers estimate that there are as many as 20,000 Mixtec speakers living in the area. Many Mixtecs are solo males, but families, many of them astoundingly young by U.S. standards, comprise a large part of the population as well.

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[42] State of California Department of Finance, Race/Ethnic with Age and Sex Detail, Sacramento, CA: December, 1998.

[43] U.S. Census Bureau, Census 2000.

[44] Larson, Migrant and Seasonal Farmworker Enumeration Profiles Study–California. Employment estimates by the state and Alice Larson's estimates used together give a range for farmworker populations.

[45] Ibid.

[46] U.S. Census 2000. When looking at the percentage of Mexicans among all declared Hispanics, the proportion is always above 90 percent.

According to our informants, migration from Ventura to other areas is common. Strawberry, vegetable, and citrus workers move into the Central Valley and up the coast to the Salinas Valley to find work.

Agricultural Patterns in the Four Regions

Agricultural Distribution, Crop Types, and Work Characteristics

Because agricultural statistics are collected by county, it is difficult to present data just for the subregions under study. Still, county data, shown in Table 3, do provide a proxy for the distribution of crops in each area. Table 4, which describes characteristics of various kinds of farmwork and implied risks by crop type, complements Table 3, allowing extrapolation of the types of crops that predominate in each region and therefore the major risks faced by farmworkers there.

In Riverside County, the ECV's 60,000 acres (about a quarter of the county) are divided between row crops and fruit orchards. There are thousands of acres of citrus orchards, plus date trees, a crop that is unique to this study area. A particular hazard for farmworkers in the ECV comes from the small farm roads that are intersected by superhighways. Farmworkers must routinely cross these dangerous intersections to travel to and from work. A public official from the town of Coachella described the problem.

> Farmworkers have older and slower cars and have to cross the huge intersections against huge trucks going no less than seventy miles per hour. When it first opened there were a few accidents, and now there are more and more.

As indicated in Table 3, Tulare County's agricultural industry is the largest in the state. In North Tulare, the main crops are citrus fruit and grapes. There are also deciduous tree fruit, including peaches, nectarines, and plums. The more than 300,000 acres of orchards

Table 3. Agricultural Statistics for the Four Counties

	Tulare	Riverside	Ventura	San Diego
Total value in billion dollars	$3.492	$1.124	$0.845	$1.289
Irrigated acres	625,000	219,000	111,000	70,000
Value of output per farm	$352,000	$343,000	$381,000	$107,000
Percent crops and nursery (value)	63%	55%	98%	86%
Percent livestock (value)	37%	45%	2%	14%
Percent nursery (value)	2%	12%	22%	68%
Acres of row crops	6,700	38,000	47,000	7,000
Acres of orchards	305,000	68,000	62,000	54,000

Sources: Agricultural Census of 1997 and the County Agricultural Reports of 2001.

Table 4. Crop Types and Associated Risks

Crop Type	Characteristics of Work	Associated Occupational Risks
Orchards, tree fruit and vineyards (e.g., citrus, dates, avocados, grapes)	Canopy management and pruning require specialized knowledge and sharp, heavy tools, as well as very close contact with chemically treated foliage. Harvesting involves carrying bags, sometimes as heavy as 80 pounds, on one's shoulders. Much of this work is conducted on ladders, sometimes at extreme heights. Lemons have particularly treacherous thorns. Table grapes are extremely pesticide intensive.	Minor and serious falls (causing injuries ranging from common bruises to sprains, muscle tears, and bone fractures), back strain, back injuries, cuts, punctures, eye and skin irritation.
Row crops (e.g., strawberries, vegetables)	Row crop work is known as "stoop labor" because of the position adopted to perform it. Some row crops require use of very sharp tools. Repetitive motions are routine.	Acute back pain, cuts, sunburn, sunstroke, repetitive stress injuries, eye and skin irritation.
Horticultural/ nursery products (e.g., mushrooms, cut flowers)	Horticultural work poses unique risks because the work is done inside sometimes poorly ventilated, pesticide-laden enclosures. Working in the mushroom industry requires special training and involves workers being suspended above the crop on scaffolding. Most mushroom growers in California have not modernized their operations like some producers in other areas have, so the work is still conducted in the dark with workers wearing miner's hard hats and lamps.	Respiratory problems, eye and skin irritations, eye strain, impaired vision, falls, back strain, repetitive stress injuries.

Note: Regardless of the crop, all farmworkers employed in industrial agriculture are routinely exposed to a variety of pesticides, placing them at risk for conditions such as skin burns, asthma and other respiratory problems, and poisoning.

(100,000 of oranges alone) and vineyards make the county quite unique. In recent years, as orange prices have declined, growers have reduced pruning, which leaves workers more exposed to injuries from thorns and falls. Farmworkers engaged in canopy management of table grapes spend a great deal of time working closely in vines that have been treated with chemicals. Only 2 percent of agriculture is nursery work in Tulare County and the number of acres of vegetables and row crops is also very small.

Much of Tulare County's agricultural revenue comes from vast dairy herds. Some workers in North Tulare work in dairy and other livestock industries and are, therefore, exposed to injuries from these large, often unpredictable animals.

Most agricultural activity in San Diego County is in the northern region, extending from the immediate coast to the inland valleys. Coastal production is mainly strawberries and horticultural products. In fact, two-thirds of the county's agricultural value is horticultural, and areas around Carlsbad and Leucadia abound with flower growers and nursery stock cultivators. The inland areas, which receive less marine influence, are dominated by avocados and citrus fruit–26,000 acres of avocados and 14,000 acres of citrus (valencia oranges and lemons). Further inland, a very small apple region is centered in Julian. Other row crops and vegetables are a small industry in the county at just 7,000 acres.

In the Oxnard subregion in Ventura County, the climate is more coastal and somewhat cooler than in North San Diego. The "wet time" that occurs as fog lifts from the citrus reduces work periods but also lowers the risk of sunstroke and heat exhaustion. The division between row crops and orchards is fairly even–47,000 and 62,000 acres respectively. As a result, the dangers associated with each kind of labor are also evenly distributed.

Photo © Jim Bratchen

The county has been steadily shifting its production away from orchards to row crops, especially strawberries. Farmworkers particularly dislike working with lemons, of which there are 25,000 acres, because of their numerous sharp thorns.

Flower growing, nurseries, and mushroom production are expanding in Ventura's coastal area. Horticultural operations now represent 22 percent of all of the county's agriculture. A United Farm Workers organizer in Ventura described the particular difficulties associated with working mushrooms.

> The working conditions are poor for mushroom pickers. They have to wear a hard hat, a belt with the battery for the light around their waist, and a miner's light on top of their hard hat, which contributes to damaging their vision due to eye strain. Often, after working eight hours, the light becomes dim and replacement batteries are not always readily accessible.

Farmworker Working Conditions

My husband was in the field. He hurt himself with a branch. When they brought him home, my husband asked him [the mayordomo] if he could wash his bag and the mayordomo told him, "No, no it's not necessary. You no longer have work."
–East Coachella farmworker's spouse

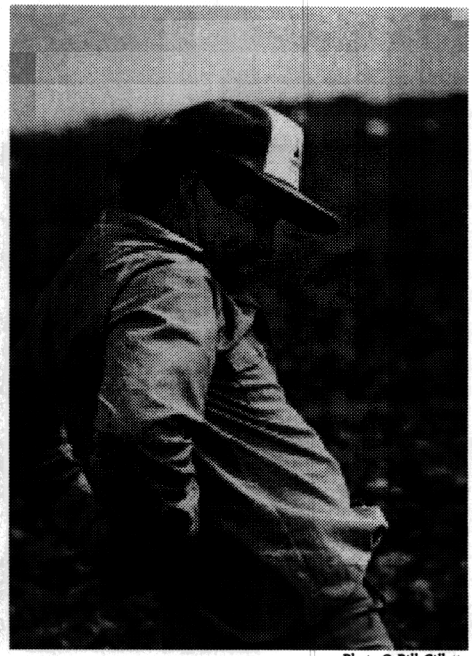


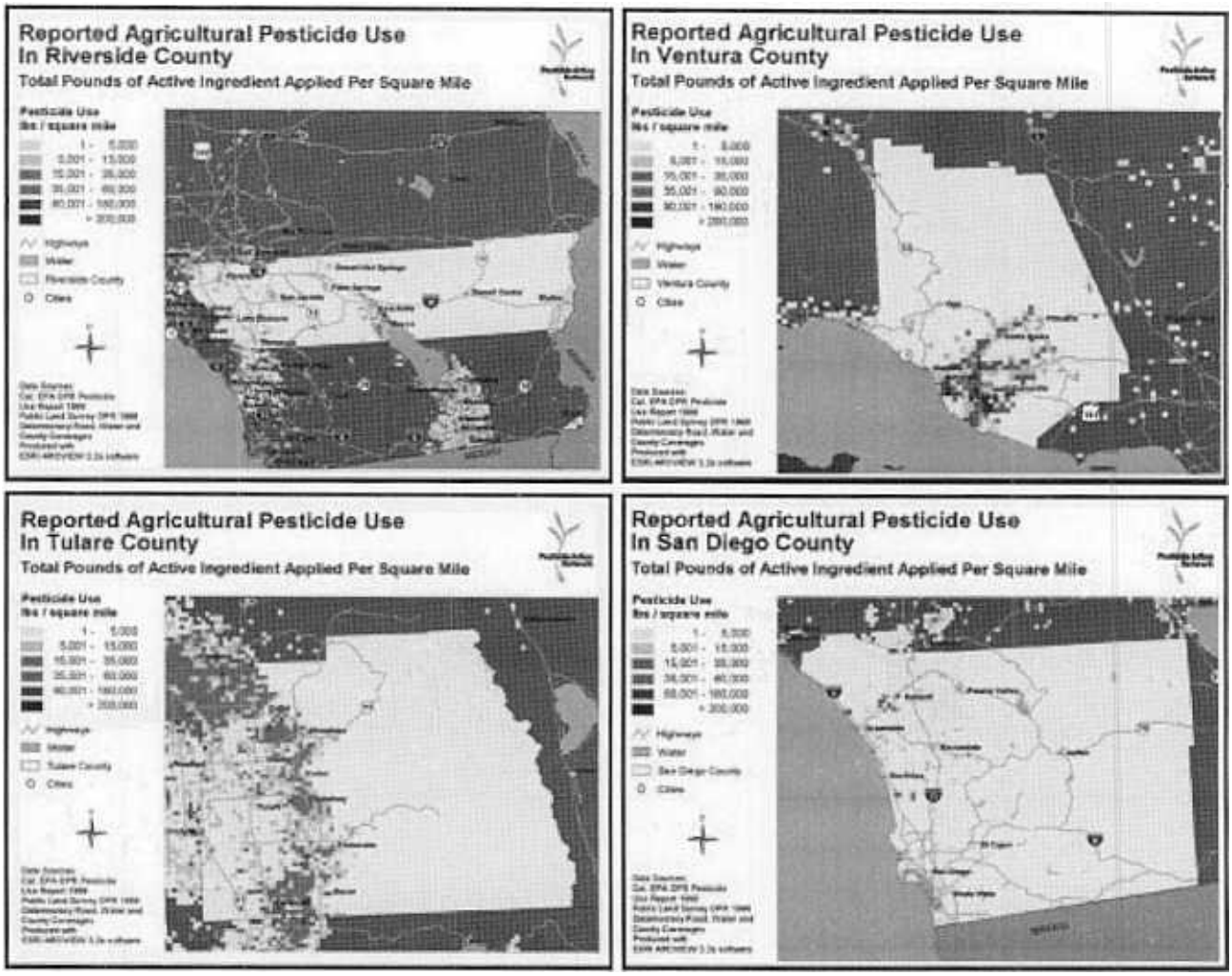
Photo © Bill Gillette

Arguably, working conditions for California's farmworkers are worse today than they were a generation ago. Real wages, after peaking in the late 1970s, dropped in the early 1980s and have remained level since. In addition, grower-sponsored housing has declined. NAWS data show that only about 5 percent of California's farmworkers have grower-subsidized housing, a figure that is much lower than both national averages and previous periods in California. The farm labor contractor system is a major force shaping hiring practices, and farm labor unions find it difficult to organize a constantly shifting labor force. Although there has been increased government monitoring of issues such as field sanitation and pesticide exposure, anecdotal information indicates that improvements are not comprehensive.

Working conditions directly affect both physical and mental health in farmworker families and shed light on various barriers to care. Physical complaints presented by farmworkers relate to handling of and exposure to toxic agricultural chemicals, dust, noxious plants, poor weather conditions, lack of sanitation and drinking water, repetitive physical motions, and uncomfortable postures required by the work. These physical assaults are compounded by exploitation and mistreatment that farmworkers suffer, treatment that impacts their mental and physical health and their ability to access health care: a compliant, frightened worker does not take care of or draw attention to himself. Instead, out of fear and desperation, he continues to work for poverty-level wages until his health fails, when he is replaced by a newer, probably younger worker. The perception of being expendable in and of itself is a debilitating psychological barrier impeding health care access.

Because working conditions vary so much from crop to crop and area to area in terms of wages, work schedules, time in the fields, number of breaks, transportation assistance, provisions for equipment, and education on health protection, it is difficult to quantify them.[47] Our ethnographic approach, however, provides an excellent vehicle for delving into such issues, detailing the treatment farmworkers receive as they perceive and express

[47] Mines, et al., The Binational Farmworker Health Survey.



it. It reveals commonalities across the four study areas and, by inference, among California farmworker communities in general.

Pesticides

Pesticides, herbicides, dust, and plant allergies are major concerns for farmworkers even though enforcement of pesticide regulations has increased in recent years. Data from the BFHS demonstrate that workers are receiving more training and are obtaining certification more frequently than before worker protection standards were applied.[48] However, it is not clear that the amount of pesticides used or the impact they have on farmworkers has declined. In the 1991–1996 period, the amount of pesticides used in California and the number of reported poisonings actually increased; in the 1997–2000 period, they declined again somewhat (according to Department of Pesticide Regulation data).[49] It is clear from the small number of reported cases that pesticide poisonings often do not get reported.

[48] Mines, et al., The Binational Farmworker Health Survey.

[49] Department of Pesticide Regulation Data, 1999. Cited from Reeves, et al., Fields of Poison.

As shown in Table 5, the four counties under study fall within the top fifteen counties in the state for reported poisonings, and the maps of pesticide use shown here illustrate the large quantities of pesticides being applied in many of these areas. The same data indicate that people working with grapes, broccoli, oranges, ornamental plants, tomatoes, strawberries, and lettuce report the most frequent poisonings.[50]

In the ECV (Riverside County), concentrations of chemicals are most notable for grapes, citrus fruit, and some row crops in the area just north of the Salton Sea. In Ventura County, it is once again the row crops and nurseries on the coast and the citrus and avocado orchards inland that receive more than 15,000 pounds of pesticides per square mile. In North Tulare, pesticides are applied heavily in the citrus belt that skirts the Sierra foothills and especially in the west toward Fresno County and south toward Farmersville, where table and wine grapes and deciduous fruit predominate. There appears to be less pesticide use per square mile in San Diego County, where the major farm industry is nurseries and cut flowers in facilities that are embedded in urban areas.

Table 5. Top 15 Rates of Pesticide Poisonings by County, 1991–1996

COUNTY	TOTAL CASES
Kern	534
Fresno	515
Monterey	428
➤ Tulare	399
San Joaquin	200
Santa Barbara	180
Kings	167
Stanislaus	138
Imperial	128
Merced	127
➤ Ventura	119
➤ San Diego	114
Los Angeles	84
Madera	79
➤ Riverside	77

Source: California Department of Pesticide Regulation, 1999.

Despite enforcement of worker protection standards by the U.S. Environmental Protection Agency, our study found that most farmworkers have not perceived improvement in pesticide application. Table grapes in North Tulare and the ECV involve intensive canopy management and harvesting that continually expose workers to chemicals on the leaves.[51] A female farmworker from Tulare County complained about the incessant push to work faster despite dangerous conditions.

> They [pesticides] do worry the worker, especially the sulfur. If it gets into your eyes, your eyes just water for like ten minutes and you can't stop. You have to keep on working. If you get behind, then she [the *mayordoma*] gets on your back.

Another grape worker, from the ECV, described the day-to-day reality of grape work.

> In the grapes, especially. There's a lot of sulfur and there are a lot of people who vomit in the fields. In addition, many have weepy eyes and suffer severe headaches. I've had nosebleeds, and my sister, Rosa, has blotches on her skin from being in the field with all of the chemicals.

[50] Ibid.

[51] Sulfur is commonly used in the table grape industry, and of the top twenty pesticides implicated in reported poisoning cases for the period 1998–2000, sulfur ranks second. It is known to cause skin rashes and irritation of the eyes and respiratory tract. See Fields of Poison, page 16.

A second ECV worker described how the bosses often make workers return too early to the fields after spraying.

> Approximately two hours before we go out to pick the grapes, they spray the grapes. Everything is still wet by the time we get in there. There are mud puddles full of the chemicals. The company provides no gloves, hats, or boots for the harvester's protection.

This same perception of an inappropriately fast return to the fields after spraying was noted in the lemon industry in the Oxnard region.

> I do think that my husband's job affects his health. They [growers] fumigate the lemons and they [the farmworkers] have to pick the lemons soon after. Sometimes my husband comes home with his eyes red. He buys eye drops.

One Oxnard informant who works with little protection did perceive improvements in working conditions.

> I did a lot of work with pesticides, as it was one of the easiest jobs available. Unfortunately, I was given nothing for protection. Often I would bring my own leather gloves that I used for picking in order to protect my hands while spraying the pesticides. However, quickly the gloves would themselves become wet. I mixed the pesticides and simply turned my head to the side in order to avoid the worst fumes. Nobody told me to wash my clothing after being exposed to the pesticides. Now, the conditions are better and disposable white suits are given to those working with pesticides.

Still, comments by providers and outreach workers confirm that exposure to pesticides persists, as noted by a provider in Tulare County.

> Let's see... We also talked about the farmworkers being exposed. We know that there is, at least where I am, a high incidence of respiratory illness. I believe that it is probably more because of their exposure to chemicals.

In the Oxnard area, exposure to pesticides in the strawberry fields is seen as a major problem by providers and farmworker advocates. An outreach worker for California Rural Legal Assistance who is a former strawberry picker described his experience with pesticides.

> I remember the burns on my arms from the pesticide use. Over time, our arms and hands would burn due to the constant exposure to the chemicals, especially if we handled the plastic around the strawberry plants. I also remember how farmworkers carrying gallons of pesticide on their backs for fumigating the crops would end up with holes burned in their clothes. One and a half years ago, two farmworkers died in a shed where the chemicals were being stored. California OSHA is reported to be investigating this incident.

Sanitation and Safety

Direct accounts from farmworkers and social service staffs associated with them help us understand the sanitation and safety challenges encountered by people who tend fields, vineyards, and orchards. In recent years, improvements in the supply of bathrooms, drinking water, and water for hand washing in the fields have been demonstrated by survey

data. In the 1995–1997 period, only 1 percent of survey participants reported no toilets or drinking water and 2 percent reported no water for hand washing.[52]

Our case study research, however, reveals a more complicated picture of availability. Many farmworkers report bringing their own water because they do not trust the quality of employer-delivered water or that it will be kept cool on hot days. They also dislike the lack of sanitary conditions under which water and bathrooms are delivered.

Photo © Bill Gillette

> *North Tulare farmworker:* Another thing that I don't like about the *mayordoma* is that she doesn't let us have our own cups of water at the workplace. She has us pass around one single jug of water that we all have to share from, so that we don't lose any time.

Women in particular complain about the lack of clean bathrooms.

> *North Tulare farmworker:* The bathrooms at work are nasty. With all of the people who use the bathroom, they only wash the bathroom once a week. The last three days, it smells so bad, but if you have to go, you have to go. The bathroom hasn't had any water for four days, so we can't wash our hands. There's no soap. People use cold water to wash their hands. They use the cold drinking water.

Another concern voiced by farmworkers is lack of time to wash and eat lunch in a relaxed manner.

> So I think that one needs to have . . . a little bit more time and a little bit more care about personal cleanliness and the time to eat, and all of that. But there are a lot, a lot of companies or people . . . that don't care about the health of the worker.

Finally, the quality of water available can lead directly to health complications, as one social worker in North San Diego noted.

> Water is also a problem. Farmworkers often do not have access to water that is clean. They are using irrigation water to drink and bathe, and this is leading to numerous health problems–gastrointestinal problems as well as skin problems and skin infections . . . Workplace injuries and conditions that are exacerbated by working and living conditions are also common. For example, these include lower back pain and fungal infections on the feet caused by having wet feet all day long, further exacerbated by socks with little absorbency and holes in shoes . . . Also, skin problems are often caused by the water itself that farmworkers use.

Mistreatment in the Work Environment: The Crew System and Its Effects

There are many levels of workplace mistreatment, everything from financial and physical abuses to psychological manipulation, that can be attributed to or are exacerbated by employment through the farm labor crew system.

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[52] Rosenberg, et al., p. 15.

Non-union farm labor is managed through a crew-boss system that invests foremen with a great deal of power. In a large and growing part of the labor market, farm labor contractors negotiate directly with growers for jobs and then hire and manage a crew to do the work. Alternatively, foremen work directly for the growers. Typically, a farmworker interacts only with a foreman or *mayordomo* who handles all recruiting, hiring, and firing of farmworkers and typically hands out payment. The contractors and foremen stand between growers and farmworkers, shifting the burden of workplace responsibility away from growers and freeing them, in the case of contractors, from any direct oversight or regulatory scrutiny.

Payment Abuses

One of the most disheartening and frequent abuses faced by farmworkers is nonpayment or underpayment by foremen for work already done. Nonpayment and avoiding payment take many forms. Often workers and foremen have only verbal agreements regarding the duration of work, payment by hour or by piece, and other conditions of employment. When pay day comes, farmworkers find that the terms of their verbal agreements have apparently changed. Other abusive payment strategies used by labor contractors and foreman include writing checks from empty accounts, writing checks for wrong amounts, undercounting hours or pieces, and questionable or illegal deductions from checks, as the following anecdotes describe.

> *North Tulare worker:* Three days later, he [the foreman] came by to drop off my check. I didn't even check my check when he was here. I just trusted him. We even talked. When I left, I realized that I was missing hours, but I was never able to get those hours back.
>
> *North Tulare worker:* We were in the grapes. He [the foreman] said, "If I see that you're not working hard, I'm going to pay you guys by the hour. So put in some desire." We did. There were four of us . . . We tried to finish a row and we didn't do it. He was paying $80 dollars. We couldn't do it, so we got out. We went to get paid and the contractor didn't want to pay us.
>
> *ECV worker:* We were working in picking lemons, and when we got our checks, they told us that they took out a certain amount for insurance. Why do they take out money if we're not even documented or do our income tax, and we don't even get unemployment? They take out more than $28 per paycheck.

Underpayments sometimes lead to agitation and even rage for victims, such as a North Tulare worker.

> I picked eight buckets worth and the *mayordomo* only marked that I had picked five buckets. I was mad. I argued with him and threw the ladder at him. I quit working for that man.

Speed of Work

Farmworkers often complain about being pressured to speed up on the job, as exemplified by comments from a North Tulare packing house worker.

> At the packing house they are very strict. You have to stand there and not look around. You cannot talk to anyone. All you can do is your task. For some it's sorting and for others it's packing.

Another typical complaint is that "bosses don't let you work at a normal pace. They want you to work like donkeys [burros]." This pressure continues despite dangerous and/or uncomfortable conditions, such as bad or hot weather.

> *North Tulare farmworker:* Well, my *mayordoma* is a person who wants work done very quickly. They pressure us a lot; they want a lot of work done. It doesn't matter to them if it is raining, or if we're not feeling well, or anything else. They want us to finish the job just the same.

Another farmworker described what happened to her husband.

> Last year he worked the grapes, but no more. One day he went [to pick raisin grapes] and came back trembling. It was like he got sun, right. He did 200 lines and he came back trembling, like this. He said, "I feel really bad." He said that he felt like vomiting. It was too hard on him.

A farmworker races through the vines, harvesting grapes on the run.
Photo © David Bacon, dbacon@igc.org

Illegal Charges and Bribes

Contractors further abuse their power by charging excessive and illegal amounts for rides, housing, drinks, and equipment.[53] This practice is illegal but very difficult to prevent. The NAWS reports that half of all farmworkers in California pay for rides and that 10 percent of all farmworkers and 16 percent of those working for contractors must pay such fees against their will. This common practice is exasperating, degrading, and financially draining for people who earn on average less than $10,000 per year.

> *North Tulare couple: Mayordomos* will ask you if you have a car. If you do, they tell you there's nothing [no work] . . . Now, you have to let them give you a ride. They don't want you to take your car. They want money.
>
> *North Tulare worker:* We are charged $25 for rides to work and then charged again for rent. And what is left for those of us who are working the fields and living in that home? Nothing but a [expletive deleted] sad life.
>
> *North Tulare couple:* There were many *mayordomos* that would take the sodas, the beer, and if you brought your own soda from your house or if you take your coffee, they would write you down for the soda [and charge you] . . . Then they take the workers to cash their checks and they'll take a cut.

Workers report frequently that keeping their jobs depends on their paying bribes or doing favors for foremen.

[53] NAWS data demonstrate that fully 30 percent of farmworkers in California are illegally charged for equipment. (Rosenberg, et al., p. 15). Equipment can range in meaning from hand tools to gloves and other protective clothing. Employees of farm labor contractors experience this in greater numbers—48 percent pay for equipment.

> The workers now have to give their *mayordomo* a twelve- or twenty-four pack of beer or they won't take you to work. Every paycheck they get they have to buy them beer. The workers know this. When they get their check, they also buy the beer and give it to him. If he doesn't get the beer, then they lose their job.

Dismissal for and Mishandling of Work-Related Injuries

A farmworker who gets sick risks being fired or the foreman intentionally mishandling the complaint to save money (or Worker's Compensation experience modules). An ECV farmworker described an employer who intentionally misrepresented a case to avoid paying the claims.

> While harvesting onions, his [my husband's] hands were badly affected by the chemicals in the soil and on the onions. His fingers were discolored purple, swollen, and remained like that until all of his fingernails fell off completely. The employer stated that they would help him, but they never did. They never reimbursed him for his sick days off from work or paid the medical bills. In fact, someone from his employer asked him to sign a document that they said stated that they would pay the work hours that he missed because of his hands and his medical bills . . . The document ended up being a document that stated that he was completely "cured" and that he no longer needed medical treatment. This document was in English.

Another employer, in violation of Worker's Compensation rules, told workers under twenty-one years old that they should not report any injuries or job-related illnesses because it was illegal for them to work because of their age. In the words of one young North Tulare farmworker, "he tells us we are responsible ourselves if we get hurt."

Intimidation and Manipulation

Labor contractors and foremen also are skilled at employing psychological manipulation and intimidation to gain their workers' compliance. Threats related to undocumented status are most frequently used.[54] One woman told about intimidation at her packing house.

> I saw that they were firing people. Since I don't have papers, and since the majority of the workers don't have papers, that's why we were afraid. Sometimes the *mayordomas* would laugh. They would say, "We can call Immigration, and they'll pick you up from here." Many of us were afraid. . . . They had us very nervous with their threats. If we weren't paying attention at work, or if we were going to the bathroom, or if we weren't punctual at work, they would threaten to call the law on us.

Farmworkers confirm that people without documents are pushed harder than others. In the mind of many, this creates an atmosphere of unfair competition between documented and undocumented workers, as described by a North Tulare farmworker.

> Well, honestly, there are a lot of people who don't have permission to work. So, for those [undocumented] people to have that work, they work beyond what a

[54] The most recent data for California (1997) show 42 percent of farmworkers are undocumented. The percent has probably increased since then. (Rosenberg, et al.)

> person should work so that they don't lose their job. . . . So, yes the *mayordomos* do give them more jobs, to those that give them the results that they want. I don't think this is right. A man must work at his pace.

One Purépecha-speaking ECV-based worker who is a legal immigrant told a story that demonstrates such defenselessness among undocumented workers. The foreman complained to this worker and some undocumented colleagues about the crew's work performance and tried to fire all of them. The worker felt that the *mayordomo* could threaten them because he thought they were all undocumented. However, the worker told him that he and all of his family were documented and could not be threatened. The *mayordomo* then said that it would be fine because there were many people who could replace them. The worker refused to leave until both the *mayordomo* and the grower signed a statement explaining why he was being fired. The *mayordomo* got tired of arguing and told the worker to get in the orchards and get to work. The other men, who were undocumented, were fired.

Discrimination

Over and above routine abuses faced by all farmworkers, there is targeted discrimination toward several subgroups–older workers, underage workers, indigenous-language people, women, and, as described in the previous section, undocumented workers.

Age comes into play because of the physically taxing nature of many farmwork jobs. Older individuals who wish to continue in farmwork often find it hard to identify a niche for themselves, and they are largely unsupported by foremen, who can always replace them with younger workers. An older farmworker described the dilemma.

> If you don't work as fast, to their standard, they'll fire you and find someone else. Also, if there's someone who's older but has worked in the fields for a long time and has worked hard for them, if they slow down, they'll get fired too. If they don't work as well as a young person, he'll get fired.

Indigenous-language speakers are particularly vulnerable and so they often passively accept the conditions forced on them. Having grown up in isolated enclaves of Mexican society, most do not speak Spanish well and have learned to accept discrimination as a fact of life, in Mexico and in the U.S. A farmworker informant made a typical assessment of the situation.

> People from Oaxaca [the indigenous] accept everything that is asked from them. For example, in the fields they're asked to do a certain amount of work and they do it. It's almost as if they don't know how to defend themselves.

Internalized oppression, social isolation, and cultural alienation among farmworkers in general and among indigenous-language people in particular are magnified by the treatment they receive at work and can lead to serious health problems that are manifested both physically and emotionally.

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Farmworker Living Conditions

Farmworkers' living conditions differ enormously across and within study areas. Rented apartments, houses, and trailers are common residences. The proportion of each in a community varies. A small number of people own and live in modest houses or trailers. A substantial portion live in makeshift dwellings or shacks, are homeless, or live in cars, under plastic, and outdoors. Overcrowding is uniformly common and may be getting worse as housing costs continue to rise in all of the study areas.

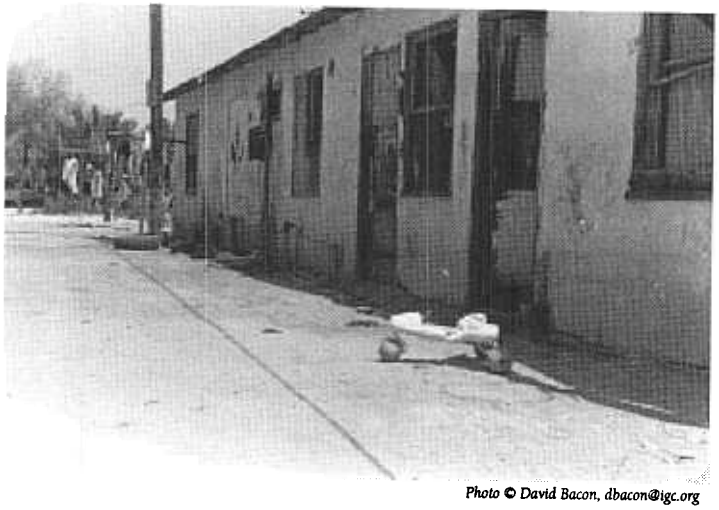

Photo © David Bacon, dbacon@igc.org

Most farmworkers in the Oxnard study area live in rented dwellings in towns; a small minority live in trailer parks and labor camps. Settled farmworkers and ex-farmworkers in the town of Oxnard live in large, suburban style homes and generally depend on several family members' incomes to afford the payments.

In North San Diego, living conditions are extremely dire. Existing housing is generally substandard and inadequate; it includes garages, overcrowded apartments, and dilapidated trailers. These conditions are due in part to the ubiquitous presence of the INS, which pushes farmworkers into remote areas and engenders a furtive existence. The region's lack of housing and fear-ridden climate lie at the root of the high rates of physical and mental health problems experienced by the farmworker population there.

Most North Tulare farmworker housing consists of rented units that range in condition from adequate to extremely substandard apartments, trailers, converted garages, and makeshift structures. Some farmworkers have been able to purchase homes, usually through subsidy programs. Because most towns in North Tulare are not incorporated, housing codes are rarely enforced.

In the ECV, trailers and mobile homes predominate, accompanied by some permanent "stick-built" homes, which are permanent structures built onsite. The term is frequently used in the ECV study region. As will be described later, much of this housing is unsafe and does not meet local codes.

A caseworker for Catholic Charities in the Oxnard region described her experience with farmworker housing there and some of its implications.

> Much of the housing is so bad that I would not even put my pet there. I have seen many migrant workers putting their newborns on blankets on the floor in

Marginal Mobile Homes and the County Loan Program in the ECV

In an area of the ECV known as the Triangle, more than half of the structures are mobile homes or trailers. According to the county Economic Development Administration (EDA), the area is home to at least 307 mobile home parks of ten to fifteen families each. Assuming five people per household, some 15,000 people live in mobile home parks. The vast majority of the parks on EDA's list lack permits and do not comply with local codes. A county official described some of the problems.

> The unit electrical system often does not have the capacity required for the appliances. The plumbing is corroded, sometimes disconnected. The potable water system and waste water systems are in some cases intermingled.

This deteriorating situation came to a head about three years ago when several farmworkers were electrocuted in a park by improperly grounded wiring. The county subsequently began enforcing housing codes, and inspections resulted in some evictions, sparking a large protest that then led to a lawsuit against the county by California Rural Legal Assistance and an investigative task force from the Archdiocese of San Bernardino. As a result, the county set up a loan program to gradually address problems without provoking homelessness among the Triangle's settled farmworker population.

That program, created in 1999 and implemented in 2000, offers loans to park owners to bring sites up to code. In addition, loans are made to tenants to buy new or improved mobile homes and even stick-built homes.[1] There have been some delays in implementing the program, and a county ombudsman appointed to mediate between the county and community (primarily park owners) indicated that progress has been hampered by tenants' need to prove trailer ownership and by fear and reluctance from owners. To facilitate the process, Desert Area Communities for Empowerment, which manages the local empowerment zone, hired a liaison. Calling the initiative the Compadre Program, the spokesperson, a park owner, actively works to bring the county and owners to terms for upgrading parks while minimizing evictions.

As of April, 2002, twenty trailer parks (housing 108 families) had been upgraded at a cost of $12 million, making the per-household cost about $36,000. With an estimated 3,000 families living in substandard dwellings, the total cost for all such trailers approaches $108 million, excluding administrative overhead.

The county loan program is widely supported in the community, and county officials consider it an innovative answer to unhealthy housing conditions. Tenants who have participated are pleased with the low payments. While the program is helping significant numbers of people escape dangerous and unhealthy conditions, given the meager incomes of tenants and even park owners, it cannot bring sufficient relief to most tenants in the medium term.

[1] Loans to owners are about $6,000 per site for improvements, and tenants can receive $30,000 to buy replacement homes. In most cases, the loans become grants if the parties do not move out for ten years.

the corner to keep them warm. Many of the houses have no door and instead use cardboard as partitions, because the landlord is too cheap. The neighborhoods are slums. Families are paying $450 to $500 for a room with access to the kitchen at certain times. They may share the kitchen with fifteen other people. Many people are homeless because they cannot afford to pay the necessary deposit. Landlords take advantage of them. They often raise the rent at the drop of a hat. You need a Social Security number in order to rent an apartment; however, you don't need one to rent a room. I have to be careful when I visit homes because sometimes the landlords think I am a code enforcer or that I will report them. Sometimes, if they have seen me come, they will kick their tenants out the next day because they think that I am with Welfare.

Solo Males and Housing

In all four regions, there are concentrations of solo males in homes, trailers, and apartments. These men often live together in small communities known as "encampments". They are also disproportionately homeless in farmworker communities. Alone, sometimes for the first time, separated from their families, these men report feeling tremendous loneliness. Faced with severe situational depression, many fall into high risk behavior, including using drugs and prostitutes. They risk not only their health but the health and welfare of the wives and children they support in Mexico.

The "Spider Holes" of North San Diego

Living conditions in North San Diego are directly related to the presence of the INS. Enforcement efforts there are particularly harsh. Farmworkers have literally been driven into hiding, living in remote areas and in highly concealed circumstances to avoid detection. Many hundreds of field workers employed in the flower, tree fruit, and row crop industries live in solo male camps in the northern part of the county where their dwellings are holes dug out of hillsides and in dry creek beds adjacent to or within walking distance of their work sites. Workers cover these shelters–referred to as "spider holes"–with brush to conceal them.

Spider holes exist in various locations–next to work sites (in Carlsbad and Oceanside), on hillsides next to major roads, and near shopping centers (Carlsbad Mall). They also occur in canyons on public lands and in avocado groves in remote areas. These living conditions are neither temporary nor seasonal. Farmworker informants have lived in such spider holes for long periods of time. One man reported having lived in one for eight years.

In North Tulare, solo males tend to live in barracks-like buildings known as camps, where communal living arrangements (shared kitchens, bathrooms, and bunkrooms) prevail. Our direct observations and conversations with farmworkers identified high-risk behavior among these men. A resident at one camp was asked about alcohol consumption at his camp and gave the following response.

> Sometimes, or I think all of the time, it is very difficult for people like myself, and many more, to come home and just feel at ease . . . to talk with the same people who live here or just to forget a little and not feel melancholy in thinking about the loved ones that one has in his country . . . Every day, every day it's the same, so that sometimes one is inclined to drink.

In North San Diego, there is uneven tolerance for the area's homeless camps. City officials have ordered them to be demolished in the Peñasquitos Canyon area, and in October, 2001, makeshift hillside camps were destroyed near Carlsbad. There

have also been incidents of violence against farmworkers in camps, the most notorious involving teenagers attacking and beating workers in the Del Mar area. As a San Diego County reporter reflected, "When the camps are torn down, the workers go deeper into hiding."

Trailers and Other Forms of Shelter

Many of the farmworkers interviewed live in overcrowded dilapidated trailers, garages, improvised shacks, and other makeshift shelters with no running water or electricity. Such conditions apply not only to newly arrived farmworkers, but also to immigrants who have worked in U.S. agriculture for more than a decade.

The ECV's Triangle (composed of the neighborhoods of Mecca, Thermal, and Oasis), commingles mobile homes and permanent or stick-built houses that are most concentrated in the unincorporated area of Mecca. Mobile home parks are mostly small and widely dispersed, creating serious transportation problems. But grouping people into more cohesive settlements implies construction of centralized sewer and water systems. Local officials are aware of the problems and have been taking steps to ameliorate them. Housing in Mecca has also been improved by the energetic intervention of Coachella Valley Housing Coalition and direct support from the county.

Trailers on Tribal Lands

In North San Diego and the ECV, some farmworkers find housing in trailers on tribal lands. Such lands in North San Diego are literally encircled by the INS, which, according to workers, sets up patrols at entrances to the reservations.

In the ECV, conditions on tribal lands are more severe than those on county lands. There are reports of water supplies contaminated with raw sewage[55] and open burning of plastic and trash, which can expose children in the vicinity of the fires to carcinogens (specifically, deadly dioxin compounds from plastics). There are also problems with dangerous electrical facilities. The Torres Martinez Tribal Council is interested in developing ordinances to control burning and manage water quality and sewage. However, they need resources to ensure that ordinances, once adopted, can be enforced. People who live on tribal lands are not considered to be county residents and thus do not receive funds under the county loan program (profiled previously), leaving them few options for improvement. One positive development is construction of a 300-unit mobile home park on Torres Martinez land that was funded by HUD and the county.[56]

[55] In this part of the ECV, where elevation is near sea level, the water table is near the surface. This can result in contamination of drinking water by sewage.

[56] The county is providing $750,000 for infrastructure improvements necessary to prepare the parks for occupancy.

Apartments and Homes

In the Oxnard region, informants reported that it is common throughout Oxnard, Santa Paula, and other farmworker communities for multiple families to live in a house coded for single-family occupancy and in garages and sheds adjacent to a home. Housing in Ventura County is costly, with monthly rent averaging $450 to $500 a month for a room. There are, however, several subsidized and low-income family residences for farmworkers. The main ones are Rancho Sespe Apartments between Santa Paula and Fillmore; Limoneira, which is still owned by the citrus grower of the same name; and Cabrillo Village.

North San Diego farmworkers employed by the nursery industry are more likely to have year-round employment and be able to afford an apartment in or near the larger towns in the area. However, our researchers observed that many apartment dwellers live in overcrowded conditions.

Community Concerns

In North Tulare, our researchers heard reports from residents about the presence of gangs, drugs, alcohol abuse, and prostitution in and around their communities, which many residents do not consider safe, especially for children. Both farmworkers and service providers reported gang activity, particularly in Cutler-Orosi, Ivanhoe, and Dinuba. Law enforcement in general is lacking because the area's towns are not incorporated, but recent improvements have been made to address some of the gang-related issues. Similar issues are a concern in the Oxnard study region, as described on the following page.

Addressing Housing Issues

Generally, there is a shortage of affordable housing for farmworkers. According to a representative for a local housing organization in the North Tulare study area, opportunities for creating affordable housing are limited by the number of sites adequate for multifamily rental property and new homes, the complexity of balancing "smart growth" with planning models, and preservation of agricultural land. In addition, many communities are further restricted by their lack of adequate sewer and water capacity.

In North San Diego, there are imposing bureaucratic hurdles. The Department of Planning and Land Use's regulations are exceptionally burdensome, prompting very few growers to undergo the lengthy and expensive process required for building worker housing. For example, one grower spent more than $1 million in legal fees in his effort to build housing for his laborers. Trailers and other temporary forms of housing are often considered illegal in the county. An attorney on San Diego's Regional Task Force on the Homeless–a partnership of public agencies, private groups, and homeless advocates–noted that part of the reason that farm owners there do not provide housing for employees lies in conflicts between state and local laws. State laws allow for construction of housing

Building Community: The Oxnard Neighborhood of La Colonia

The La Colonia neighborhood in the city of Oxnard is the hub of the farmworker community in Ventura County. The neighborhood is bounded on the west by railroad tracks and extends ten or so square blocks. It has all the elements of a functioning community, including churches, schools, markets carrying Mexican products, commercial streets, parks, and heavy foot traffic. Farmworkers congregate at various pick-up points as early as 4 a.m. for scheduled rides or to be hired for work.

Residences in La Colonia vary from well-kept owner-occupied houses to run down houses occupied by multiple families and other shared arrangements. Some properties have trailers or shanty structures wedged behind the main building that serve as housing for farmworkers. A soon to retire police officer who is involved in community development in La Colonia offered some details about the neighborhood.

> In terms of housing in La Colonia, 40 percent are owner occupied and 60 percent are rental properties. There are also a lot of subrentals. I would say that approximately 30 percent of units have eight to ten people in them. Housing is a problem here. In terms of Section VIII, there is a five-year waiting list.

Photo © Jim Bracken

Today, only a couple of the twenty bars that once operated in the community remain thanks to recent efforts by Oxnard police and other community groups to clean up the area. The police department runs "Weed and Seed," a program that, from an unobtrusive store front in the center of the city, focuses on building community for all groups in La Colonia and aims to reduce youth violence. This effort also has reduced the graffiti that once covered residences and commercial establishments there. Recently, the Weed and Seed program cleared an empty lot to prepare for a community garden.

There are some in the community who see the crackdown on bars and graffiti in La Colonia as merely superficial signs of authoritarian pressure. They recognize the need for expression and release in a community struggling to survive in an unfamiliar environment and that bars allow people to socialize and get information about work and life, particularly for solo males. They argue that the real need is to inform, educate, and support farmworkers with basic direct services. These divergent points of view demonstrate the involvement of the community in a healthy effort to improve itself, as well as the community's well-developed social structure. This level of experience and interest on the part of community leaders in La Colonia will be helpful in implementing additional programs and services there.

for farmworkers on agricultural land, but local laws are more restrictive and challenging them in court is expensive.

A farmworker camp in the marshy center of a strawberry field
Photo © David Bacon, dbacon@igc.org

The legal hurdles in San Diego County are set against a backdrop in which communities' self-identification favors an economy based on tourism and the U.S. military, not on farming. Trends in funding for farmworker housing reflect this. For example, the county's Regional Task Force on the Homeless recently claimed that more than half of the homeless people in San Diego County are farmworkers and day laborers. At the same time, funds spent on housing for this subgroup dropped from about $1.3 million in 1995 to only about $171,000 in 2002, even though the total amount spent on the homeless in general doubled during that period.

In spite of such trends, there have been positive developments in the county. The town of Carlsbad has inclusive housing ordinances mandating that new developments there must include medium- and lower-income dwellings. Another example is Encinitas, which built a twelve-unit project in an unusual override of general public sentiment against lower-income housing. San Marcos also has a relatively high percentage of housing designated for farmworkers.

In Ventura County, plans for family residences for farmworkers around the county are in various stages of development. One county official explained the current work of the Committee to Address Farmworker Housing.

> The committee focuses on housing for low-income farmworker families. We have various members on the committee, including representatives from CRLA, UFW, members of the Cabrillo Economic Development Association, and various county planning people. Overcrowding is a big problem. Our objective is to build housing specifically for families so that less people have to live in one unit.

Living Conditions, Health, and Access to Care

Across all four regions, the most common problem associated with living conditions is overcrowding, which was confirmed by direct observation and farmworker comments. Informants relate stories of dozens of individuals living in a single dwelling. In addition to the health risks involved in high-density living, sharing space can create problems accessing health care when farmworker families must establish residency to gain low-cost health care but have no utility bills in their names as proof. Other common unhealthy living conditions identified by service providers include lack of heat and air conditioning and lack of telephone service.

Homeless camps create ideal conditions for spreading infectious diseases, and both farmworkers and surrounding communities suffer when there is no sanitation or potable water. In some cases, farmworkers drink irrigation water at nearby work sites. All these practices exacerbate health problems, particularly gastrointestinal diseases and skin infections. In addition, public disdain and intolerance of farmworker encampments, despite the lack of alternatives, in places like North San Diego make it difficult for outreach workers to build the trust and inroads needed to provide services to the farmworker community.

An outreach worker in the Oxnard region shared her perspective on farmworker health and the link to living conditions in the area.

> Tuberculosis is a problem among this population, particularly because of the close living quarters. I am on a communicable disease committee (through the county) that is receiving funds from the tobacco settlement, and we are looking at the issues confronting farmworkers. For example, no access to water. The incidence of HIV/AIDS is increasing in the county and statewide amongst the Latino population. This points to a need for more attention to this issue.

Similarly, in San Diego County the incidence of tuberculosis is attributed to crowded, unsanitary living conditions. Tuberculosis among Latinos in San Diego County is ten times higher than it is among non-Hispanic whites.[57]

The dispersion of trailer parks in the unincorporated areas of the ECV creates transportation hurdles that, in turn, impact farmworker access to health care. Public transportation from the parks to more populated areas like Coachella is virtually nonexistent. Women and children are particularly affected, as they generally remain in the parks while male family members take the family automobile or receive rides to work for the day.

[57] Healthcare of San Diego County, County of San Diego, 2000.

CALIFORNIA INSTITUTE FOR RURAL STUDIES

The Health Care Landscape: Points of Entry to Health Care across Farmworker Communities

When a farmworker becomes ill or injured, the first thing he or she is likely to do is try to ignore the problem or use existing channels within the community to rectify it, including self-medicating and seeking care south of the border. When these efforts fail, individuals are faced with the often daunting task of navigating U.S. health care systems. There are various points of entry to health care, and this section provides some background on each, with specific comments refracted through the lens of individual farmworker communities.

Resources, politics, and the organization of health care delivery systems influence how accessible such systems are to the farmworker population. At the primary care level, each of the four study regions is being served to various extents by: 1) community-based health centers;[58] 2) county clinics; 3) free clinics; 4) hospital emergency rooms; and 5) private, for-profit operations.

Photo © Bill Gillette

In some areas, farmworkers confront a mix of these providers and varying degrees of service coordination, while other regions are dominated by one or two provider systems. In fact, the four study areas demonstrate unique distributions of primary care providers. For example, only one county clinic serves North Tulare, an expansive region dominated by federally qualified health centers (FQHCs). In North San Diego, there are no county-based medical services; instead, there are four public health units staffed by nurses. In the ECV, the county clinic in Indio serves farmworkers, but most must travel long distances to reach it. In Oxnard, there is a well-developed, farmworker-oriented county clinic system.

Each organization presents a unique combination of policies, services, and staffing that profoundly affects farmworkers' respect for and subsequent reliance on their services and access to specialty care through referrals. Through personal interviews and community-based studies, our researchers canvased the providers who are on the front lines of daily delivery of such services to farmworkers.

[58] Not all nonprofit clinics opt to have community-based boards of directors, and they therefore do not qualify for FQHC or FQHC look-alike status.

Community Health Centers / Federally Qualified Health Centers

Community-based health centers designated by the federal Centers for Medicare and Medicaid Services as FQHCs or as look-alikes[59] collectively serve a significant proportion of farmworkers in the four study regions. These clinics are mandated to serve areas and populations designated as medically underserved. In return, they receive cost-based reimbursement for the portion of services not covered by Medi-Cal or Medicare. However, people are accepted regardless of their insurance status or ability to pay. Uninsured, low-income patients pay for services on a sliding fee scale that is discounted based on income. The clinics often are able to obtain reimbursement for costs not charged to uninsured patients.

FQHCs and look-alikes are designed to provide comprehensive health services, including primary care, dentistry, optometry, and mental health care. In some cases, specialty care is offered as well. Access to specialty care varies, but in general providers find it difficult to obtain referral services for farmworkers, particularly for non-emergency cases and those involving Medi-Cal patients and the uninsured. As one nurse practitioner in a rural clinic put it, "The biggest barrier is the lack of ability to pay for many of the clients. When we have to send patients to referrals, that leads to difficulties."

In the ECV's Mecca-Thermal-Oasis Triangle, which has a population of about 50,000, there is just one small FQHC. Clients with Medi-Cal can be referred to JFK Hospital in Indio, but indigent clients (those ineligible for Medi-Cal) must travel ninety minutes across the mountains to the county facility at Moreno Valley. In the Oxnard region, a major FQHC tries to bridge the enormous gap in specialty care for the uninsured and underinsured by contracting with specialists, formalizing the relationships to ensure patient access. The major FQHC clinic consortium in North Tulare does not provide specialty care; a referral specialist arranges outside services for patients, often negotiating reduced fees for the indigent. North San Diego's community-based clinics also have systems in place for locating specialists and tracking whether patients complete the appointments. They use lists of specialists willing to work pro bono or for reduced fees. Unfortunately, there is no data on how many people that system includes.

In addition to offering linguistically appropriate services, FQHCs in the study regions often demonstrate cultural competence in services and programs targeting farmworkers, including indigenous-language speakers. These centers frequently provide a wide range of community services and enabling resources to facilitate patient access to and use of available care. Such community services can include outreach/promotora services, community health education, transportation assistance or services, and social services. Outreach services often tackle a broad range of topics, including diabetes, nutrition, asthma, reproductive health, and sexually transmitted diseases. Programs such as Child

[59] FQHC look-alikes receive cost-based reimbursement for Medicaid and Medicare and comply with federal Section 330 grant requirements but do not receive the federal grant.

Health and Disability Prevention, Breast and Cervical Cancer Control, Breast Cancer and Early Detection, and other publicly funded health screenings operate extensively through these centers. Unfortunately, the quality of the health education delivered by such centers varies greatly from area to area. In three subregions, clinics offer education departments to local residents. The fourth, in the ECV, is isolated from its parent consortium, and education services are not available at the local clinic.

Community-based clinics also vary in the primary care resources available to them. In North San Diego, where the farmworker population is a distinct minority embedded in mainstream majority communities, the clinics have garnered resources but have a difficult time maintaining their focus on special services to farmworkers. Despite the challenges, one North San Diego clinic stands out for its focused outreach targeting farmworkers, delivering services directly to the underserved solo male and encampment populations. In the ECV, the pervasive poverty and isolation in the area restrict resources to the community-based clinic. In North Tulare and Oxnard, resources are also limited, but the focus on farmworkers has been easier to maintain. For example, an Oxnard-based health center operates an extensive outreach program, as described by a clinic representative.

> We do have a mobile health clinic, one of the smaller components of our outreach. Our outreach consists of fifteen to seventeen people that have responsibilities in the health centers for education and classes. Outside the centers, they do outreach to fields, packing houses, laundromats, local community stores, housing areas, and health fairs. We do the mobile medical clinics at different school sites that have a difficult time accessing health care otherwise. We take a physician assistant or a nurse practitioner out there so we can often provide the care right onsite. We take medications and injections with us so that we can treat what we can. If we can't treat it, we will set up an appointment at our clinic. We are trying to link patients to outreach programs that exist. Currently, we have about fifteen promotoras and one of their jobs is to let the farmworkers know that we exist. They can ask farmers where their crews are on a particular day and then the outreach workers can go to them.

While the use of mobile clinics is generally a positive trend in addressing health care access and building trust within a wary farmworker population, the approach has demonstrated limited effectiveness against chronic conditions, which require ongoing therapy and careful monitoring of treatments. An outreach director at a major clinic in North San Diego voiced this dilemma.

> The problem with mobile clinics is that it fragments health care. It is very difficult to treat ongoing problems such as chronic health conditions. Patients needing ongoing care will not get it.

Free Clinics

Free clinics in the study regions offer farmworkers access to services without cost, and consequently the supply of such services is often quite limited. These clinics are funded by grants and donations and generally are staffed by a cadre of medical volunteers. They often operate under the auspices of religious organizations. There are free clinics serving

farmworkers in Oxnard, North Tulare, and North San Diego, but none were identified in the ECV. Services at these facilities generally include primary care, dental services, health education, health screenings, free prescription medicines, and access to basic and/or emergency aid such as food, clothing, and shelter.

Some free clinics provide additional services. In the Oxnard region, a free clinic operates a van service for outreach and transporting patients. In North Tulare, the only free clinic in the county provides once-a-week services on different days for medical surgery, pediatrics, obstetrics and gynecology, podiatry, and dental care. They have four examination rooms, a dental unit, and a pharmacy and approximately fifty volunteers. Still, resources and staffing limit the number of patients served, according to a representative for the clinic.

> That's one of my bigger challenges. The worst is, I can't do all I want to do. I can never see everybody that wants to be seen. And it's very difficult to turn people away. You know, you come in Tuesday morning and there'll be fifty people here. Some of them have been here since six o'clock [in the morning]... See these? [a stack of patient records] These are waiting for referrals to specialists. These are all for dermatology, which I have a hard time getting, but right now I have a dermatologist on the hook who is promising to come one hour a month.

One question left unanswered by our research in regard to free clinics is whether patients achieve continuity of care or use them more for one-time treatments and specific medical interventions.

County Clinics

In three of the regions studied, county-operated clinics play a relatively small role in delivering health care to farmworkers. In the ECV, the county clinic in Indio serves many farmworker families but is difficult to get to from farmworker neighborhoods; in North Tulare, the clinic in Dinuba is the only county clinic in the region, and there are no county clinics in North San Diego. However, the county's primary care infrastructure in the Oxnard region extends into farmworker communities, reaching even indigenous-language populations through a full-time Mixteco translator who has pioneered a monthly support group for socializing and exchanging information (described later in this report).

County clinics generally offer comprehensive primary care and prevention services, including health education, family planning, health screenings, immunizations, and testing for infectious diseases such as HIV/AIDS and tuberculosis. These clinics also provide access to programs such as Child Health and Disability Prevention and link patients to WIC and other social service programs.

Emergency Rooms at Hospitals

Emergency rooms represent another point of access to health care among farmworkers in the four study regions, and for many, this setting is their first contact with the U.S. medical establishment. A wide range of circumstances can lead a farmworker family to seek care at a hospital emergency room. Though it is difficult to generalize, some reasons include lack of awareness about other health care resources, an inability to access preventive care, being uninsured and/or ineligible for public programs, apprehension about using other kinds of U.S. institutions, inability to pay, and not recognizing the severity of an illness or injury until the situation becomes critical.

Our research indicates that farmworkers tend to be quite dissatisfied with the care they receive in emergency rooms. Most are typically bothered by how long they must wait and the cultural insensitivity to which they are subjected. In the ECV, distance is an issue as well, as the local hospital in Indio does not accept uninsured, non-emergency patients unless they pay for services. Patients who do not have the money must go to the emergency room at the Moreno Valley hospital, which accepts indigent patients. An ECV trailer park owner and community activist elaborated on the difficulties involved.

> If you don't have insurance, they won't serve you at the [Indio] hospital. If you don't have money, you have to go over to Loma Linda or Moreno Valley, which is an hour and a half away. They have to go in their own vehicles. The ambulance costs $600 just to get to Indio.

His friend elaborated further.

> They don't have eyes that see the *Hispanos*. In the emergency room, they don't give you any service but still send you a bill. We are invisible, and there are no services provided for us.

A hospital administrator from North Tulare shared his take on emergency room use by farmworkers.

> Statistically, 80 percent of the time patients that come to the emergency room do not need emergency or urgent care. Granted, some of those 80 percent are here because they don't know what they have, such as heartburn . . . but there are others who may actually be here for real problems, such as cardiac reasons, that need treatment. On the other hand, there are many that come here for lack of access, and they come to the most expensive site for care and receive episodic care as opposed to longitudinal care.

In some cases, hospitals staffed with eligibility or social workers link farmworkers and their dependents to support programs such as Medi-Cal, California Children's Services, and the local county's indigent care program, facilitating their entrance into the health care system. But emergency room visits can leave indigent, uninsured adults with insurmountable debts that take years to resolve, while hospitals must contend with uncompensated care. Such has been the experience of a young North Tulare farmworker who had undiagnosed diabetes and ended up in an emergency room.

> I was beginning to not feel well while I was in the fields. One day, I ended up in the hospital in Dinuba. I slipped into a coma for twelve days and ended up being in the hospital for nearly a month. My blood sugar was too high. The doctors told me what I had to take, and to change my eating habits. I did change my eating habits . . . and I am down to one insulin injection per day. It was three before. When I got out of my coma, they told me that I didn't have much time to live, but here I am today. Right now, I am buying my medicines from the local pharmacy. It costs about $100 a month to control my diabetes. I am screwed on medical debts though. For when I was in the hospital for so long, the bill is $17,000. I don't have any Social Security, insurance, or Medi-Cal, so it's nearly impossible to pay. I mean, after earning what I earn, paying for lunch, a ride, and rent, I'm once again broke . . . Every check I receive gets diminished bill by bill.

Private For-profit Clinics

In general, across the four study regions, FQHCs, free clinics, or county clinics serve most of the uninsured, Medi-Cal, and otherwise publicly insured patients.[60] But in each region, a few private for-profit clinics and solo practitioners have been identified as providing health care to farmworkers. The extent of their use is difficult to measure, but it is clear that these providers shape their service delivery according to their consumers' preferences. In contrast to a managed-care approach and the gatekeeper structure of health care common in the U.S., some private for-profit providers in farmworker communities offer services resembling those in Mexico. They often minimize waiting, diagnose and treat patients expediently, and offer a higher degree of patient-directed health care. However, clinic fees and payment schedules vary, and the cost is generally higher than that of community clinics. In addition, sliding fee scale discounts do not apply, and some providers demand payment up front.

Prevention services, health education, and outreach are usually beyond the purview of private for-profit providers. However, in one region, a clinic operating under the direction of a family nurse practitioner delivers numerous prevention services, conducts Child Health and Disability Prevention assessments coupled with developmental health education, and offers breast examinations through the state-sponsored Breast Cancer and Early Detection Program, family planning services under Family Pact, and HIV testing. In another region, members of the farmworker community favor the treatment of a solo practitioner who is described as both culturally and linguistically competent. A clinic staff member familiar with this physician indicated the reasons for his success.

> Dr. [name withheld] gives shots easily and asks for payment up front. It is faster to go to him since he minimizes paperwork. He prescribes what you ask for.

[60] Private physicians and especially HMO physicians are much less likely to take Medi-Cal patients than are community clinics. This is particularly true for specialists. Medi-Cal Policy Institute, Physician Participation in Medi-Cal, 1996–98.

Behaviors and Attitudes

Affecting Access to Care and Impeding Treatment of Chronic Conditions

The vast majority of California's farmworkers are first-generation Mexican immigrants. They bring with them a range of beliefs and attitudes that influence their behavior around accessing U.S. health care. This section explores how, as farmworkers come into contact with our institutions, their behavior and attitudes prevent them from seeking health care in a timely fashion, aggravating existing health problems.

Cultural and Situational Factors

When farmworkers and their families enter the U.S. health care system, they bring with them health beliefs and practices that are rooted in the culture and society of Mexico. Some of these differences are then magnified by the unfamiliar living and financial conditions they experience as U.S. farmworkers.

Dietary Habits and Reliance on Prepackaged or "Fast" Food

Generally, "fast" and prepackaged foods offer an inexpensive and convenient alternative to healthy eating. Farmworkers' taxing schedules and meager incomes make it difficult to afford healthy foods, and in some regions their neighborhoods are far from supermarkets. Fresh fruits and vegetables can be obtained only in a neighboring town. A nurse in North Tulare described her own problems buying food.

> When I first moved into the community, I kind of went into some culture shock myself because they had one tiny little market and you're really limited. I mean, nutrition is a big, big problem. The parents may be diabetics, but the parents just don't understand that your child needs to eat healthy too. They give them unhealthy food, they cook them unhealthily, and make unhealthy choices. But you look at the grocery store [in town] and my God, I'd have to go grocery shopping elsewhere, because boneless, skinless chicken breast does not exist. I want parsley; it does not exist. Low-fat cheese? Can't find it. Olive oil? You can get bottles this size [very small]. I want bottles of olive oil this big because that's what I prefer to use. [When asked about lard and other high-fat foods] . . . Oh yeah, they're there and good prices. *Chicharones*, *longuisa*, *chorizo*. It's all there.

Solo males in particular tend to rely on fast food since they are not used to cooking for themselves; traditionally, they would be cared for by a mother or wife. On their own for the first time and often lacking adequate kitchen facilities, they have few alternatives. Moreover, farmworkers from rural areas who have limited schooling are especially vulnerable to marketing campaigns for fast food and prepackaged meals that are easy to prepare but high in sodium and fat. Farmworker children, eager to assimilate and eat like Americans, also fall prey to marketing efforts and consume excessive sweets, which contribute to poor dental health.

In our four study areas, diabetes and chronic heart disease are prevalent. Both ailments can be regulated through dietary precautions; studies show that diet and moderate exercise reduce the risk or delay the onset of Type II diabetes by 40 to 60 percent.[61] Lack of health education outreach, stressful living situations, feelings of helplessness stemming from situational depression, and lack of alternatives all make maintaining a healthy diet difficult.

Exercise

Few farmworkers report regularly engaging in recreational sports or activities. The reasons for this are both cultural and situational. People from rural communities typically do not engage in or understand the concept of exercise as something separate from daily activities. They believe that their exertions throughout the day are adequate. This is particularly true among people who previously relied on bicycles, animals, or walking to get around in Mexico. As U.S. farmworkers, these people physically exert themselves on the job, but their activities are not necessarily healthful or aerobic. Moreover, after a farmworker has put in long hours at work, there simply may not be time or energy for additional activities.

Photo © David Bacon, dbacon@igc.org

It is also important to keep in mind that most farmworker neighborhoods do not offer many recreational facilities, and the strong INS presence in areas such as North San Diego further discourages farmworkers from pursuing outdoor exercise. The farmworkers who did have opportunities to participate in recreational activities, particularly the people separated from family, claimed that it had a positive effect on them mentally and that it aided social interaction.

Attitudes toward U.S. Doctors

Members of farmworking communities are used to the particulars of care prevalent in rural and small-town Mexico, which is characterized by short waits, little laboratory testing, no paperwork, minimal record keeping, and access to fast-acting medicines. Farmworkers' expectations of the U.S. health care system and their disappointment with the care they receive are manifested in a variety of ways, creating reactions of both awe and distrust of medical practices in this country.

Some farmworkers distinguish between the ability to diagnose and the ability to heal. They believe that doctors can analyze diseases and diagnose illnesses, but are less skilled at curing those conditions. In the words of a North San Diego farmworker who sees a

[61] *www.niddk.nih.gov/health/diabetes/pubs/dmstats/dmstats.htm#4.*

curandero (folk healer), "the *curandero* can't tell you if you're well. The doctors do the analysis." This worker believes that a *curandero* can cure him, though only the doctor could tell with certainty when he was cured. *Curanderos* are folk medical specialists or healers who administer therapies based on ritual cures. *Sobadores*, on the other hand, are folk therapeutic masseuses or chiropractors, though the two may share techniques for diagnosis and treatment.[62]

The extent to which farmworkers seek care from *curanderos* and *sobadores* was not assessed in this study. However, many farmworkers in these regions demonstrated faith in traditional healing practices and often resorted to such methods before turning to the U.S. medical establishment. The combination of distrust and concern that doctors cannot cure them is compounded by concerns that U.S. doctors have greedy ulterior motives. As a result, farmworkers often do not return to a U.S. doctor for consultations after the first visit, making continuity of care impossible and precluding them from receiving services for which they are eligible.

Self-diagnosis, Home Remedies, and Self-medication

Farmworkers and their families commonly self-diagnose problems and turn first to home remedies and self-medication before approaching a health care facility. The high cost of treatment, their general lack of insurance and/or documented status, and other barriers contribute to this tendency. Self-medication was widely reported in all of the study areas. Some home remedies are popular everywhere while others are unique to particular areas. A farmworker in the ECV described her understanding of home remedies used by people living in the trailer park.

> I use home remedies. For the throat, a tea with *canela* and *yerba buena* and a little of *gordo lobo*. If the cough has phlegm, add lemon and honey. Later, you can add Vicks Vapor Rub. You either die or you make it. It's good. It works. There are people who can *soba* [act as a *sobador*]. But that is bad because you get bruised all over. It is no good.

Culture-bound syndromes, illnesses suffered by farmworkers of Mexican origin that are not recognized by the U.S. health care establishment but very real to those who experience them, are also common. Some examples of these illnesses are *nervios* (anxiousness), *empacho* (digestive distress), *susto* (fright), and *mollera caída* (sunken fontanels in infants and toddlers).[63] Because health care providers in this country often meet such complaints with skepticism, farmworkers feel that their concerns are not taken seriously or that the doctors are poorly informed. A farmworker's spouse talked about doctors' attitudes toward such conditions.

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[62] Mines, et al., The Binational Farmworker Health Survey.

[63] Mines, et al., The Binational Farmworker Health Survey. In the Binational Farmworker Health Survey, 12 percent of respondents reported suffering from a culture-bound syndrome.

> They don't know. They don't know about *empacho, mollera caída* that you sometimes see in children who can't eat. They don't know. How are they going to do anything if they don't know?

A North Tulare provider commented on the risks associated with the tendency among the farm workforce to seek alternative avenues of health care.

> We do know that people who do not have access to health care will find different alternatives. Again, breaking through the cultural beliefs and stereotypes of going to a *sobadora* for health care and not fully understanding a certain diagnosis, such as diabetes, can cause them more harm. Farmworkers believe that the disease was caused because someone gave the farmworker the evil eye or used witchcraft on them. . . . We know that people go to the *remate* [flea market] and they buy self-prescribed medication or they call their relatives in Mexico to send over prescriptions.

This provider looked upon alternative forms of care with skepticism. He and many others do not seem to approve of alternative remedies, considering them to be at best ineffective and at worst harmful.

Seeking Care in Mexico

Farmworkers in all four regions have long gone to doctors across the Mexican border since they believe physicians there offer cheaper and more satisfying and immediate results. Farmworkers in the ECV exhibited a clear preference for treatment in Mexicali over the U.S. Indeed, there are farmworkers who, despite having insurance, return to Mexicali for treatment because services there are less expensive and they prefer the style of treatment. A worker in North San Diego described his approach to health care, which is typical of many farmworkers. "I go outside [of the U.S.]. Here in the U.S. the task of getting care is more burdensome." He travels to Tijuana for health care but not to any particular provider. "I go wherever I end up." Recently, he relied on Mexican pharmacies to treat his health problems, including a molar that was bothering him last year. He had originally seen a dentist in Tijuana for the same condition. The dentist prescribed an antibiotic that he obtained from the pharmacy. Rather than return to the dentist when the problem returned, he simply went back to the pharmacy and requested the same medication since it cured him the first time. He explained that, because he had the same problem again, it was only necessary to go back to the pharmacy. This account illustrates the tendency toward self-medication among farmworker families who cross the border for health care.

In the Oxnard region, a similar trend was observed, but many younger farmworkers there neglect health care altogether. According to a local merchant in Santa Paula, "For health services the single men go to Tijuana if they have papers. If not, they just put up with it [the health problem]."

Dental care in Mexico is attractive for similar reasons. Standards of care for dental work in the U.S. often result in thousands of dollars worth of work involving multiple stages and appointments. Dentists in Tijuana typically perform tooth extractions for a much

Spotlight on Dental Health

As previously noted, dental disease ranks as one of the top five health problems for farmworker family members ages five through twenty-nine and remains among the top twenty health problems for farmworkers of all other ages presenting for care.[1] Dental problems include broken teeth, toothaches that can last months, loose teeth, difficulty eating, decay, and cavities. Poor or nonexistent hygienic practices, lack of insurance coverage, an inability to pay for care, unreliable transportation, and the limited number of providers in some areas all contribute to the pervasiveness of this entirely preventable health condition.

The ECV farmworker population provides a case in point. Even though there are a few dentists in the area, most do not accept Medi-Cal. Some farmworker families who are documented and can cross the border easily see dentists in Mexicali. Many farmworkers simply forego care. Others get discouraged after interfacing with the U.S. health care system and do not want to participate. An example of this attitude is a man who went to a provider in Indio to get a tooth extracted. When he went to the dentist, they told him they could not extract it because he had an infection and had to first have a course of antibiotics. Then, when he returned to the dentist, he was given an anesthetic that did not start working until after his tooth was removed and he was in his car driving back home to Mecca. The extraction was very painful. He feels that providers in the U.S. just want to take people's money.

As in other regions, farmworkers in Oxnard see dental care in Mexico as an attractive option as it is much cheaper and the health care landscape in Mexico is familiar. An Oxnard farmworker expressed his distrust of U.S. dentists.

> The dentists here have a way of grabbing customers that I didn't like. They don't explain how you will be charged. They try to hook a person and not give him a way out. They say they can't tell you anything until they get an x-ray. Then they won't give you a choice of what they want done. I just wanted a cleaning. I didn't feel like I should have to pay for the x-ray and exam. They should have told me up front what they were going to charge me.

Despite provider efforts to meet the dental needs of residents (prevention efforts, mobile units, and sliding fee scales), serious dental conditions remain widespread among farmworkers and their families. Service providers support continuing dental health education and prevention efforts while increasing access to affordable services for uninsured children and adults. They are particularly concerned about underserved farmworker children.

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[1] Lombardi, Dental/Oral Health Services.

smaller fee and may also offer simpler, though perhaps temporary, solutions at a much lower cost.

Treating Chronic Conditions

The inclination of the farmworker community to seek alternative treatments and care in Mexico has prevented them from getting well acquainted with health care systems in the U.S. In turn, because so many individuals do not request care, the system is not being pressured to better adapt to the needs of this population. This particularly becomes apparent in connection with chronic conditions, which, because they are neglected by farmworkers and their families, too often develop into crises. Patients suffering from chronic diseases such as diabetes, cancer, and asthma go undiagnosed and/or untreated and can wind up in emergency rooms.

Chronic diseases are widespread among the farmworker populations we studied, with medical providers repeatedly mentioning diabetes, hypertension, and heart disease together as related health conditions affecting farmworkers.[64] A provider in the Oxnard region stated that, in terms of chronic illnesses, he sees obesity, coronary heart disease, diabetes, and hypertension frequently. He attributes this mainly to diet. When he identifies these illnesses in patients, he personally counsels them by giving basic nutritional advice. Another provider in the same area seconded his opinion and also recommended trying to improve health behavior.

> Some chronic diseases that we see include hypertension, diabetes, and obesity. Outreach regarding such diseases would be excellent if conducted during lunch breaks. Such outreach could attempt to effect behavioral change as well. Those diagnosed with diabetes or hypertension are required to see a health educator. Working on a farm all day does not promote healthy eating, as many eat tacos on the go due to the pace in the fields. Also, lunch wagons on the sites carry unhealthy food.

In this section, we share both farmworker and provider perspectives on the challenges of treating chronic conditions, touching on issues related to prevention, health education, and patient compliance.

Preventive Practices among Farmworkers

Service providers consistently identified difficulty instilling the value of preventive practices and early diagnosis in farmworkers, who tend to take a symptomatic approach to health and seek care only after an illness becomes serious. A provider in the ECV discussed this tendency. "With diabetes, basic everyday care is overlooked and people only come into the clinics when there are complications." Providers also linked poor health outcomes for this group to their overall lack of health care information and services.

[64] While we did not gather specific health data for each of the four regions within the confines of this study, the co-occurrence of these health issues has been established from findings from the CAWHS and other sources.

Regarding breast cancer, a provider explained that the Hispanic/Latina population actually has a low incidence of breast cancer but a high rate of mortality among those who do have the disease because they generally do not have access to preventive diagnostic care and so are not diagnosed until the disease is advanced.

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Accounts by farmworkers in the four regions support providers' assertions about the lack of attention paid by the farmworker population to preventive health care. Among farmworkers with diabetes, some were either hospitalized or experienced advanced symptoms such as vision loss before their conditions were diagnosed. A farmworker with severe diabetes recounted the day he was diagnosed at a North Tulare clinic. "The machine could not detect it [blood sugar level], I had it so high. So high that I went over the highest [value] on the machine."

Similarly, an Oxnard farmworker's response to whether there were any chronic illnesses in her family highlights the degree of misunderstanding in these communities about issues such as diabetes and the urgent need for health education.

> Sometimes I think that my husband has high blood pressure and diabetes. A long time ago, they told him that he had the precursors for diabetes, but he didn't pay attention to it. My mother died of complications from diabetes and one of her sisters did too. I haven't been checked for diabetes. Maybe I suffer from it too. I don't see well, and it's probably due to something like diabetes. I can't read because I can't see well. I need glasses.

Providers confirmed that stories like this are not rare. Many in farmworker communities do not realize that they are suffering from a chronic ailment until a screening identifies the condition, as noted by a provider from Oxnard. "Lately, I have seen what a big problem diabetes is for the farmworker population. At a recent health fair, we found a whole family with diabetes."

The Need for Effective Health Education

There is regional consensus in all of the study areas that health care education is urgently needed to head off disease and increase patients' compliance with treatments. Providers like this physician from Oxnard emphasize the value of health education in helping people manage chronic diseases.

> We need to provide better health education for this population, to include diabetes, nutrition, heart disease, dental care, immunization, STDs, HIV, and breast feeding (as too many mothers use formula).

A North San Diego representative for a community clinic supports increased health education and prevention efforts, particularly by way of the promotora model.

> This would also include support groups for diabetics. There has been a rise in gestational diabetes and obesity . . . [the clinic] would like to target childhood obesity prevention and is currently targeting the zero to five age group by providing nutritional information and other kinds of outreach to mothers.

This pressing need for additional health education was acknowledged in all of the study regions, including North Tulare, which already has one promotora program addressing diabetes, the Diabetes Community Intervention Project (profiled later in this report).

Spotlight on Mental Health

Among both worker and provider informants in the four study areas, there was nearly complete agreement that mental health problems are widespread in the farmworker population, a conclusion that is not surprising given the severe stress farmworkers and their families endure in coming to the U.S. and in their day-to-day living and working conditions. The following excerpt from *Mental Health and Substance Abuse*, a publication of the National Center for Farmworker Health, offers a summary of research documenting depression in the farmworking population.

> Furthermore, researchers have documented that high levels of depression among migrant farmworkers are associated with high acculturative stress (Hovey & Magaña, 2000), low self-esteem (Hovey & Magaña, 2000), discrimination (Alderete et al., 1999; Hovey & Magaña, 2000), low religiosity (Hovey & Magaña, 2000), lower income (White-Means, 1991), physical health problems (Vega et al., 1985), and lack of child care (De Leon Siantz, 1990a).
>
> In addition, among first-generation migrant farmworkers in Michigan and Ohio, Hovey and Magaña (2000) found that individuals who willingly immigrated to the United States and willingly chose to do farmwork were less depressed than the farmworkers who did not freely choose this path. This indicates that the relative lack of control farmworkers have over their lives plays an important part in depression among migrant farmworkers.[65]

Our conversations with farmworkers identified additional conditions that influence situational mental health: poor housing conditions, exploitation at work, fear of deportation, prolonged separation from family and friends in their home country, and lack of recreation and transportation.

Language and Institutional Barriers to Diagnosis and Treatment

Language and institutional barriers complicate effective diagnosis and treatment of mental health problems. Farmworkers and their families often have difficulty communicating easily and openly, which makes it harder for mental health providers to identify the specific problems. A public health nurse in North Tulare explained the challenges she faces.

> Especially for the non-English-speaking population, this is a difficult thing. It is hard enough to work with people who speak the language and know the system; it is very difficult to find services for people who are having mental problems and are undocumented.

In cases when situational depression is diagnosed, there are few publicly funded options for low-cost treatment, as noted by a clinical psychiatrist in the Oxnard region.

> At the Department of Mental Health, we don't take the moderately mentally ill, only the severely mentally ill. For the moderately mentally ill or for the people with short-term mental health problems, there really is nothing.

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[65] Hovey, Mental Health and Substance Abuse.

A bicultural/bilingual North Tulare social worker and therapist indicated similar problems.

> Mental health is in crisis in this state and probably in the nation to where there are not enough therapists, and especially not enough bilingual/bicultural therapists. . . . Also, those that work for the county have great restrictions. They only deal with the severely mentally diagnosed clients. So, mothers that are depressed will not qualify for mental health services in the county office.

As a result, early signs of mental health problems often are not treated until after the condition generates more serious anti-social behavior. Attorneys, social workers, and private practice mental health providers frequently described how mental health problems are being identified largely through the criminal justice system after an arrest. At that juncture, court orders require people to attend Alcoholics Anonymous or counseling for issues related to domestic violence and substance abuse. Had an intervention occurred earlier through the health care system, the more serious problems and legal consequences perhaps could have been avoided.

Few therapists speak Spanish. Even fewer are able and willing to offer affordable therapy to the farmworker population. A Mexican-American clinical psychiatrist in the Oxnard region explained. "I can't see indigents or farmworkers who cannot pay because I have to pay the rent. I do very little pro bono work. There is no place to refer them." A senior clinic administrator in the same region described one possible approach to increasing the number of low-cost mental health care services to Spanish speakers.

> We are trying to have the marriage and family therapists qualify to bill Medi-Cal for their services, which is currently not an option. This is important because most of the Spanish-speaking people are MFTs [marriage and family therapists], not psychologists or psychiatrists. This would open up a huge resource for bilingual people providing mental health care.

Awareness of and Attitudes toward Mental Health within the Farmworker Community

Unfortunately, there is considerable stigma attached to mental illness within farmworker culture. In the ECV, staff members at the county mental health clinic claim that this cultural stigma discourages families from bringing mentally ill relatives to the clinic and from enrolling them in the day treatment center. Others report that farmworker families often try to protect psychologically disturbed relatives from the system. Similar attitudes were reported by mental health professionals in all four study regions.

> Trying to deal with mental health alone is difficult since this population is not willing to seek help with personal problems outside the family. [The farmworkers believe] dirty laundry is washed at home.

In North Tulare, a county nurse elaborated further.

> A lot of people do not want to admit to having mental disorders . . . being "crazy" so to speak. And they're in denial a lot because people don't have a real concept of mental illness like they do of physical illness. I think too that's why we're

> trying to do more education in mental health. That's one area that we need to get rid of the stigma.

Most of the farmworker informants in our study did not understand the concept of trying to seek help for psychological issues. They often approach such problems with a fatalistic attitude, which can make it very difficult for mental health providers to attain the continuity of care necessary for success.

Researchers also observed a preference in farmworker communities for religious solace over psychological treatment. This preference is illustrated by the words of an ECV farmworker diagnosed with breast cancer. When asked how she dealt with her illness and whether she had seen a therapist to help her cope, she said, "My psychiatrist is personal, private, and his name is God." She feels that God helped her detect the lump to give her a second chance. She has been invited to go to support groups, but she wants to deal with the cancer as it takes its course. She does not want to know what she could potentially face, saying it is better for her not to be told to "be ready. You're going to get cancer." She feels she has dealt with the illness very appropriately and is not anxious about it. No one in her family has received mental health services.

Our researchers received similarly deterministic responses related to substance abuse, such as a belief that alcoholics reach a point of no return. A fifty-year-old farmworker summed up his situation: "I'm already hooked. I've screwed myself. What can I do?"

Fear of Immigration Authorities

Fear of INS was omnipresent in all of the regions studied. The ECV in particular is seen as a "landing area" for new immigrants, and INS, known colloquially as *la migra*, has a strong presence there. The ongoing anxiety associated with INS has a deep impact on the psyche of the population, and checkpoints in the region severely restrict mobility for many. People from the ECV, according to outreach workers there, prefer not even to go grocery shopping in the town of Oasis because they fear authorities, particularly between December and July, when INS's presence is strongest. "They don't go grocery shopping and they don't go to see the doctor. Only if one of their children is really sick. That is the only time when they decide to go out."

In North San Diego, the intense presence of INS patrols throughout the county undermines the stability of local farmworker communities by weakening the social networks that normally serve as support. According to a community outreach worker there, "INS is active in North County because they have permission from towns and their residents to be aggressive in the area." Informants from the region report feeling that they are constantly under scrutiny. A twenty-year-old worker from Guadalajara who lived with his father and brothers described his experience. "I am not free here . . . I cannot go anywhere." According to this young man's father, his son suffers from *nervios*. Reflecting on the psychological isolation that farmworkers experience, several of the region's informants echoed similar feelings.

Clinic administrator: Farmworkers are starving for social interaction, and need counseling services and other social diversions.

Promotora: One of the main issues for farmworkers is that they live in fear and do not feel free. This has huge mental health repercussions that we, as outreach workers, deal with daily.

North San Diego farmworkers we interviewed were more aware than those in other regions of their substandard living conditions and extreme isolation. They expressed interest in mental health and recreational activities that could ease the daily grind, but they were also concerned about how participation might expose them to authorities. In addition, we observed a willingness on the part of some providers in the region to strengthen the promotora model, ultimately drawing more people into mental health care once the promotoras have an opportunity to earn the community's trust.

In the Oxnard region, anxiety about INS came through the words of a seventeen-year-old farmworker's wife.

> People are afraid of *la migra* because they can grab you and send you back to Mexico. I've never seen them, but I have heard stories. I've heard in the news about how in San Francisco they take people away. I worry that it could happen here.

Some informants related terrifying experiences while trying to escape the INS that continue to haunt them. For example, a farmworker from the Oxnard region told how he was waiting for a ride one day and *la migra* chased him. He hid in someone's backyard, but inside the yard was a large dog that jumped at him and pinned him against the wall. Eventually, the dog backed away and didn't hurt him, but the experience was traumatic. He said that it still gave him *nervios* during the day and that he has nightmares about the incident. He also said that, looking back, he would have preferred being caught by *la migra* to having experienced the terror of his run-in with the dog.

In North Tulare, farmworker informants report generalized anxiety about immigration authorities. A farmworker in the region explained how she felt nervous about being fired from her job at any time because she did not have papers.

> I felt lots of *nervios* because I would say if they fire me, where am I going to get work? I felt headaches and *nervios*. I also felt *hormigadero* [tingling in my hands] and I was very nervous. I saw that they were firing people.

In response to a question about whether she received threats at work about the INS, she responded, "Oh yes. Since I don't have papers, and since the majority of the workers don't have papers, that's why we were afraid."

Separation from Family, Social Isolation, Homesickness, and Depression

As with most first-generation immigrants, farmworkers coming to this country often find it very hard to adjust and adapt to a new culture. Lack of familiarity with many aspects of the U.S. system, new work environments, low incomes, and homesickness often lead to depression. One ECV farmworker stated that she suffered depression when she first arrived

in the U.S. In fact, she said it was the saddest time in her life because she arrived here without her children, who stayed with her sister in Mexico. She did not seek mental health services for her depression. She would only talk to her husband and a few other female friends within the trailer park.

Longings for home were also reflected by many in North San Diego, as in the case where a man shared the difficulty of coping with feelings of sadness, "sadness for thinking about those persons who are not here, the nostalgia." He misses his town and his family and friends. But he admitted that he does nothing in response to these feelings. "I don't do anything. There is no remedy." In addition, he asks rhetorically, "What could I do? Leave, or just withstand it?" He did not know of any programs offering mental health services. While he was in Mexico, he had considered obtaining services from a psychologist, but in the end, he did not pursue it. Revealing signs of situational depression, he mentioned that he feels *coraje*, a combination of emotions involving anger, frustration, and outrage, saying, "everything that happens in this world . . . People do not understand things. Adults are teaching children about weapons."

Photo © David Bacon, dbacon@igc.org

In the Oxnard region, a farmworker spoke of the sadness and pain he suffers due to separation from his family.

> I don't really like it. I'm here out of necessity. Maybe if I had my family with me it would be different. Being here without my wife is very hard for me. I've been thinking about bringing her [and his infant son] over here, so that we can handle staying a little longer [before going back to Mexico].

Referring to his desire to be with his parents, a farmworker from the same area described his feelings.

> Sometimes I think I want to have time to go spend some time with them [his parents in Mexico], but I don't have time. Sometimes I get sad and I don't feel like working. I think about my parents. I work alone and I don't have anyone to talk to. I think about my parents and about my siblings.

Undocumented immigrants, generally a majority of the farmworker population, are faced with longer periods of separation because they cannot easily cross the border. A farmworker from Dinuba in North Tulare explained. "Those who have papers, well yes, they come and go every season. And those that don't have [papers] don't return for two or three years, because it's very difficult to cross."

An ECV farmworker described the problems she had to face when she arrived in the U.S. She and her family had no work, no money, and no home. She said she suffered from *nervios* during that time. Her immediate family lived with her brother for a while, and he

helped them financially. She had just had her baby. Her husband wanted to return to Mexicali, but she refused to go back. Although this depression lasted for approximately six months, she never spoke to a counselor or a psychiatrist. When asked about mental health therapists in Mexico, she said that there are psychiatrists in Mexicali, but that they are very expensive. She said that "people would rather spend their money on food than psychiatrists."

Domestic Violence

Frustration, anger, and societal isolation in the farmworker community also provoke addictions to alcohol and drugs and inflame domestic violence in families. In all four study regions, domestic abuses were prevalent, though they did not always reach the level of physical violence. Women describe feeling tremendous stress from financial pressures, domestic issues, and their separation from family in Mexico. They report experiencing guilt and depression if they have difficulty finding work, and some women newly arrived from Mexico are intimidated and mistreated by their partners. Contributing factors include marrying young, a lack of affordable child care, inability to work due to undocumented status, and separation from support networks. Many feel trapped in their life situations and find it hard to break out, which often leads to severe depression and mental health ailments.

The stigma associated with sharing such problems outside of the family only makes matters worse. For example, in the ECV, numerous female respondents professed that they had problems of sadness, depression, or abuse, but none of them reported going to a counselor. Though more than half of the population of the ECV are Spanish-speaking, only about one in twenty of a Riverside County mental health counselor's patients speak Spanish.

A social worker who serves North Tulare described how child abuse is often correlated with domestic abuse.

> We find that for a lot of Hispanic women, that it is very difficult. They've been acculturated to just accept and so it's very difficult to get them out. . . . We find that when they finally decide to do something, the domestic violence is now descending down to being abusive towards their children. . . . Typically there's a strong correlation with domestic violence and child abuse. So we always screen for child abuse when there is domestic violence in the home.

In the Oxnard region, a "from the ground up" approach was proposed for handling domestic abuse faced by women in the area, according to a social worker.

> There are large gaps in the county's mental health care system. Individuals with substance abuse or mental health problems aren't accepted at shelters. Also, shelters don't accept children who are over thirteen years of age. The shelters' cultural relevancy varies. Some are better than others. There are not enough Spanish-speaking counselors or therapists in the mental health system. There aren't even any non-English-speaking therapists for children under the age of

women safe in their homes. We need to work with the whole families. The men can be leaders and role models in this regard. We can base ourselves on the strength of the family.

Alcohol and Drug Abuse

Farmworker informants offered conflicting accounts regarding the extent of alcohol and drug abuse problems in their communities. Interestingly, women indicated that alcohol and drug abuse are prevalent among male farmworkers, including their spouses. Their accounts ranged from daily alcohol consumption (usually after work) to social drinking on weekends. In addition, some informants spoke of alcohol consumption on the job and described people using illicit drugs to increase their stamina at work. By contrast, solo male informants perceived that alcohol consumption helps subdue feelings of nostalgia, isolation, and loneliness and creates opportunities for social interaction.[66]

Generally speaking, farmworkers indicated that financial stress and emotional anxiety lead to heavy drinking. As a provider in North Tulare explained, "Alcohol is a big problem in the community here. Depression has a lot to do with that." A farmworker from this region shared his view of how depression and heavy drinking are correlated.

> The main drinkers are the workers that come to pick peaches and grapes. They mostly drink during the weekend, on Saturday when they get paid. They come here to the U.S. alone without their wives. In years past, the majority of the men came alone, and about three to four years ago there was an increase of men bringing their wives. I see that they're happier. They no longer worry if their kids are eating, or if they're okay. I think that's why when they come here alone they drank a lot. They got depressed. I've seen them with their families. Yes, sometimes they drink one or two beers because they're thirsty, but not really to get drunk.

Despite the prevalence of alcoholism in all four regions, some awareness about avoiding addictive behavior was observed. A North San Diego farmworker said that he plays soccer or goes running to stay busy, thereby curbing feelings of sadness and boredom. The same worker described how drinking becomes a problem. "Whenever one feels sad, the mind begins to work more, especially when one is overcome by nostalgia. Others respond to these feelings by drinking [beer] heavily." This farmworker also seemed to be aware of the financial drain created by regular alcohol consumption and wanted to safeguard his earnings.

Although some workers receive therapy through drug or alcohol rehabilitation programs, others refuse to recognize the problem or seek treatment. In some cases, family members

[66] As described earlier in *Overview of Farmworker Health Status*, the BFHS (2001) found that, among current and ex-farmworkers, 75 percent of men and 11 percent of women drank alcohol. Thirteen percent said that they drank every day.

seemed to have difficulty recognizing signs of alcoholism or were in a state of denial, such as an ex-farmworker in North Tulare. "I have a son-in-law that drinks a lot, but I don't think . . . well, I don't know. Is it alcoholism?"

Barriers to Accessing Health Care

Having described the farmworker population and generalities of the health care landscape, we turn to an analysis of the barriers to health care access encountered by farmworkers. We highlight what farmworkers themselves perceive as barriers, but also include the point of view of medical practitioners and of outreach workers who promote health care to the farmworker population.

Health Insurance

Most workers reported having no health insurance coverage. Health providers, farmworkers, and community members repeatedly stated that very few farmworkers receive off-the-job health insurance from employers and only receive Worker's Compensation. Employers usually do not provide health insurance to seasonal workers, which comprise the majority of their crews. Detailed insight into issues associated with health insurance in the farmworker community can be obtained from the findings of the CAWHS (1999) and the BFHS (2001), both conducted by CIRS. Please refer to Tables 6 and 7 on the following page.


Photo © Bill Gillette

While the CAWHS found that 70 percent of adult employed farmworker respondents had no insurance,[67] the BFHS noted a somewhat lower rate of 58 percent. For whole households, about one-half of BFHS respondents had no insurance. The number of participants estimated to be enrolled in indigent state medical programs was also a small proportion of the sample under analysis. With regards to employer-provided insurance, the CAWHS showed about 12 percent making use of such benefits, while BFHS farmworker households demonstrated a higher proportion of 25 percent.[68]

Shifting from statistical overviews to the four individual study regions, we found that many providers reported that farmworkers lack access to health care because they cannot

[67] The sample size was 971 currently employed farmworkers found in seven small farmworker towns distributed across rural California.

[68] On average, respondents in the BFHS were more settled and connected to services in the U.S. than were respondents in the CAWHS. The median age in the CAWHS was thirty-four while in the BFHS it was forty-three. Also, a third of the respondents in the BFHS were ex-farmworkers.

afford to pay–whether with cash or through health insurance coverage. Though this assessment is fundamentally accurate, it reveals that providers downplay other less tangible barriers that farmworkers face in interactions with U.S. health care. When physicians "go by the book," farmworkers are liable to slip by despite the practitioners' best intentions. One FQHC doctor explained how his choice of medicines depends on the insurance plan involved. "I follow the formularies of the programs and look at the insurance constantly."

Table 6: Health Care Insurance Coverage and Health Care Utilization (N=971)

Uninsured	70%
Employer-provided insurance	11.4%
Medi-Cal/IEHP & Medicare/Medicaid	7%
Never been to a doctor	25%
Never been to a doctor or no visit in last year	57%
Doctor visit in last two years	60%

Source: California Agricultural Workers Health Survey (CAWHS), 1999.

Workers' perceptions are important as well. In some cases, workers distrust their job situations and even the concept of insurance, to the extent that some believe that they have no coverage but never actually check to see. This perspective is reflected in a North San Diego farmworker's comments. He reported that at his job site the bosses say that they offer some type of health coverage, but he does not believe they actually do. When asked if he had heard of anyone who tried to use the insurance but had problems or had to pay, the worker remarked that he had not heard of such a case. He mentioned that "a coworker twisted his wrist and his *patrón* [crew boss] sent him to a *curandero* instead of a doctor." He acknowledged that he would accept the copay if in fact his employer actually offers insurance, but he repeated that the option did not truly exist.

Table 7: Insurance Coverage for Farmworker Households (N=467)

Uninsured	49%
Employer-provided insurance	25%
Medi-Cal	19%
Private	7%

Source: The Binational Farmworker Health Survey (BFHS), 2001.

Though having insurance represents an important step toward access, it is not a guarantee; farmworkers are impeded in accessing proper services in other ways as well. Despite having coverage, an older couple in North San Diego, for example, described the difficulties they experienced with the vision services he receives through Social Security. "It took us three months to get my wife the glasses she needed through the Social Security services."

Awareness of Services

The degree to which farmworkers are aware of services that are and are not available in their communities is influenced by the migratory and seasonal nature of farmwork and by their typically limited education and English abilities. Many are not aware of social service programs for which they qualify. Some don't understand or believe in the concept of insurance–the idea of paying a premium now and not paying the bill when one becomes sick is foreign to many of them. Moreover, in many cases, awareness of and willingness to utilize social and health services is hampered by undocumented status and the concomitant isolation. As a farmworker in the ECV explained, "When we first came to the U.S., we had no idea of the available programs. We did not know about Medi-Cal or any other indigent programs."

A North San Diego farmworker who suffered from a drinking problem shed further light on the impact of lack of awareness about services in the community. He was not opposed to getting professional help for his drinking problem, but said that he did not know where such services could be found. Similarly, an Oxnard farmworker's wife said she goes to a particular clinic because it is the only one she knows about. A North Tulare farmworker family did not even know where to go in case of emergency. "We don't know where to go for an emergency. We have never had health insurance, and we have never tried to apply."

Support and health services related to domestic violence are scarce in the farmworker community, although it is an issue encountered in everyday life. A social worker in Oxnard explained that many cases of domestic violence go unreported because families fear being separated as a consequence. In many cases, victims do not know who to call or what their rights are under the Violence Against Women Act.

Word of mouth is a primary way to enhance people's awareness about health programs. As a farmworker in North San Diego described, "the way people find out about services is like a chain, and people are the links." In general, providers emphasized the crucial necessity of direct outreach in linking the farmworker population to the U.S. health care system.

Language and Cultural Barriers

In the four regions analyzed, language barriers were identified as a pervasive hindrance in accessing health care. Farmworkers, being primarily first-generation Mexican immigrants with a median education of six years, usually do not speak English.[69] The communication gap this causes in the doctor-patient relationship is further complicated by cultural differences. Immigrant workers are used to quick, paperless, test-free, culturally familiar medical care. The emphasis is on immediate relief of symptoms rather than

[69] See Rosenberg, et al., Who Works on California Farms?, page 8, for educational levels of farmworkers.

on long-term cures and preventive measures. One Mexican physician in a highly migratory area of rural Zacatecas gave a clear example of these feelings. He said that, when he asks his sick patients whether they want to stop the pain or cure the disease, they invariably ask to stop the pain.[70]

Long waits, excessive paperwork, multiple visits before treatment, time-consuming and expensive tests, administration of medicines that patients perceive as weak, and a general lack of attention from U.S. doctors leave many Mexican immigrants extremely suspicious. Our informants often expressed anger at the way they are treated by the U.S. system, and they question the motives behind the behavior of health care personnel. They often believe that the paperwork, tests, mandatory return visits, and reluctance to give "strong" medicine (i.e., antibiotics) are done intentionally to keep patients coming back for more services so they can be charged more money.

Undocumented farmworkers are keenly aware of the social stigma in the health care system that comes with their status. In the words of a North Tulare woman who suffers from a reproductive health problem and prefers treatment in Mexico, "Here [in the U.S.] one is humiliated, humiliated as a result that one does not have papers." In addition, providers who express skepticism about culture-bound syndromes such as *nervios* and *empacho* inadvertently belittle the experience of Mexican patients, further alienating them.

We observed that providers, while acknowledging cultural barriers, consider language to be the most significant barrier in the doctor-patient setting. Many providers do not speak Spanish and must rely on translators. In the ECV, for example, among the clinics that serve farmworkers as a first point of entry, only seven of the fifteen physicians and mid-level practitioners speak Spanish, and only one of those speaks it as a first language. In all study areas, the dearth of translators impacts clinic efficiency. Spanish-speaking staff members are frequently pulled away from their primary tasks (e.g., drawing blood, taking biometric measurements, the pharmacy) to serve as translators, reducing their productivity, increasing delays for patients, and limiting the number of patients seen each day.

In addition, farmworker patients, like most people, report that they prefer to speak directly to a doctor. A physician in Mexicali noted that this is one of the major reasons that patients cross the border for medical care. A provider in the ECV noted that "always when there is a translator the doctor-patient relationship is lost." There are almost no specialists who speak Spanish, particularly in mental health, where relying on translators is especially problematic. A doctor in the ECV, for example, endeavored to speak to his patients in his poor Spanish in an effort to provide more direct doctor-patient contact. But the issue is not so simple to resolve, as the ECV provider explained.

[70] See Mines, et al., The Binational Farmworker Health Survey.

> You need to know how the patients think. They think differently than other populations. They are loyal to their doctors. They listen to what you say. You have to understand their culture. They have different needs, different ways to see medicine.

CIRS researchers, through participant observations, noted that staff members who speak Spanish still may lack the cultural competence necessary to effectively and successfully interact with the farmworker population. An outreach specialist in North Tulare commented on the issue of cultural competence among physicians.

> It is not enough for doctors to speak the language, but it is very important to understand the culture also. Speaking Spanish is just one aspect of it all, but if doctors do not understand the culture of the people they are trying to serve, people can either be tuned out or might feel disrespected. That has been expressed to me quite a bit. You know, the comfort zone of the farmworkers.

Finally, the words of a North Tulare ex-farmworker summarize the issue of language and cultural competency.

> The doctor that I have does not speak Spanish. And then he sends me to the doctor here in Exeter . . . A very good doctor. But the bad thing is that we cannot reach a good understanding. He doesn't understand me, and I don't understand him either. Because he doesn't speak Spanish at all and I don't speak English, right? And he sends me to a specialist, a neurologist in Tulare. And he ended up like the others. That doctor doesn't speak Spanish. And I tell them I won't go anymore. Because every time I go, the doctor doesn't even turn around to look at me. All he does is stand there and write and write.

Indigenous-language Subgroups

Mixteco and other indigenous-language farmworker families face even greater challenges stemming from their profoundly different cultures. They typically come from areas of Mexico that offer little formal education and no formal health care systems, so they lack literacy skills and have no experience accessing such facilities. Interviewers have observed that indigenous-language people tend to have an inherent respect for authority. This respect, combined with discomfort at being in someone else's country, often leads them to avoid accessing services and prevents them from advocating for their own care. Both in Mexico and in the U.S., Mixteco and other indigenous-language people tend to live in remote areas and lack personal transportation. As is often true among farmworkers, few speak English, but these immigrants frequently do not speak Spanish either, and some of their indigenous languages do not have a written form. They comprise one of the most destitute and downtrodden subpopulations of immigrant farmworkers. A successful intervention with this group must be sensitive to their cultural qualities in drawing them to needed services.

Health Education and Education Materials

There is little disagreement that all four regions need more bilingual, bicultural health education programs and materials. Some programs are available for medical conditions

such as diabetes, but often they are not offered in Spanish. The ones that are in Spanish are usually not located in or tailored to the farmworker community. To make matters worse, health education materials tend to be overly complicated, failing to take common literacy and education levels into account.

Informants for this study confirm that the farmworker population is not likely to participate in preventive health maintenance measures like pap smears and other screenings due to the lack of health education, cultural taboos, and the inability to bear the high costs of care in the absence of health insurance. As a provider in the ECV stated, "In terms of prevention, people are getting better. However, they have no formal education system in place for prevention." Health education that is not driven from the level of practice, like that informed by promotoras (cultural brokers), is not likely to be effective.

Provider Perspective

Providers concur that language and cultural barriers create obstacles for efficient delivery of services, but they offer additional perspectives. A provider in North San Diego described one of the cultural differences that causes problems.

> Another problem is a social thing. Hispanic patients tend to bring the whole family to the hospital for appointments. The hospital has no child care. This places a burden on waiting rooms, [affects the] ambience of the hospital, and is inappropriate.

Another doctor/entrepreneur who runs clinics in both farmworker and middle class areas offered the following analysis and was not shy in describing the financial disadvantages of serving the farmworker community.

> In the middle class office, there are four to five people sitting and reading magazines. They have their Visa or Mastercard; they talk to the doctor for a few minutes, understand their problem, and move on. Eighty can be seen in a day easily. The number of labor hours for the middle class compared to the farmworker office is 15 to 20 percent less. In the farmworker office there will be a group huddled around the desk. Many come at 8:00 a.m. despite having appointments later on. Many don't come exactly when their appointment is. Many are upset or angry with the treatment they are getting. They bring their whole family, and they bring in friends or relatives who are sick too. They can't fill out the papers. So that 30 to 40 percent more employees are necessary to fill out forms for them. By the time I get them through the system, it takes me 30 to 40 percent more cost. It is not the quality or efficiency of the two offices but because the patient population is different. The doctors who work in the farmworker office will work for 30 percent less in the middle class office than in the farmworker office because it is easier to work there. The doctors will complain that the place is confusing and disorganized. The farmworker office doctors are paid more. That's the only way to keep them there.

Transportation

Farmworkers, providers, and outreach workers have all acknowledged transportation as a major hurdle to accessing health care in farmworker communities in the four study

areas. In general, farmworkers often have limited access to any form of transportation, making even travel to local clinics a serious challenge. Many farmworker families cannot afford a car. If they can afford one, the male head of the household typically takes it to work, leaving his family without personal transportation. In places like the ECV, where the farmworker community is dispersed in remote, isolated pockets (including tribal lands), the difficulty is even more acute. Specialty care and services through the Medically Indigent Services Program require travel outside of the area. Dependence by family members on the head of the family for transportation makes any appointment difficult to keep, as voiced by the wife of an ECV farmworker.

> Well, sometimes I cannot go. I can't go because it [the appointment] is made too early and my husband doesn't come home until after 2:30. I don't always know when the bus will come. There isn't anyone else who could go with me.

Another farmworker family member stated that her transportation problems make it impossible for her to keep appointments consistently. "Sometimes, I do try. Sometimes I can't because I don't have a ride."

Public transit systems in the ECV and elsewhere find it difficult to impossible to cost-effectively serve remotely located farmworkers and remote rural areas. A philanthropist there outlined the limits of the system.

> Transportation is a tough issue since the transit authority can only send two lines down there and the population is dispersed. The Sun bus system has very few buses in ECV because the population is dispersed and the lines don't pay for themselves.

Even in regions where there is a relatively well-connected public transportation system, such as Oxnard, difficulties remain. Problems commonly associated with using any type of public transportation system are compounded by immigrants' lack of familiarity with the system, conflicts between bus and field work schedules and between bus and clinic schedules, and the likelihood of having to spend long periods waiting at medical facilities. In more populated cities in the Oxnard region, the public buses will take people to clinics free of charge if they can show that they have an appointment at a clinic.

Providers generally recognize the transportation hurdles that farmworkers encounter in accessing health and social services. Bus vouchers and van pick-ups are available in some areas to help farmworkers travel to clinics, but providers do not have the resources needed to handle the demand. A provider in the Oxnard area described the pressures.

> We do have vehicles in which we occasionally transfer patients to the hospital for an appointment. We try not to advertise that too much because it ties up resources that we don't have.

The lack of resources results in transportation services that are not reliable or consistent, and there is duplication of some services among clinics, all of which discourages farmworkers and their families from using them. Outreach programs in the Oxnard area's

various clinics would benefit from collaborating more closely in order to improve their efforts in transporting farmworkers.

As a consequence of the difficulties connected with public transportation, farmworkers who can afford a car are quick to abandon public transportation despite the risk of being stopped by law enforcement and consequently losing the car due to lack of insurance, registration, and other requirements that are difficult for undocumented workers to obtain. A young undocumented farmworker in Oxnard, for example, reported that one of his major anxieties was fear of being stopped for a driving infraction and having his car confiscated.

The experience of the farmworker community regarding transportation has not been very positive in North Tulare either, as a medical provider explained.

> Transportation is a big problem for a lot of our clients. All we can do is assist them with ideas of getting a neighbor to help them or a friend to take them to the clinics. Maybe Dial-a-Ride or bus routes, but there is really no one out there to transport people.

As previously noted, harsh INS policies in North San Diego discourage people from venturing beyond their homes or shelters and jobs. These people's isolation in distant camps and trailer parks, together with their fear of traveling, makes access to health care a risky proposition. A local farmworker described the restrictions. "Life is hard here because one is trapped. One can't go anywhere because the INS will catch us. I am tired and discouraged by having to live on the hill in a hole."

Transportation issues severely restrict the effectiveness of health education efforts as well. While male family members are at work, their spouses and children often have no way to get to facilities offering health education, as noted by a provider in North Tulare.

> The majority of my patients, about 60 percent, are diabetic, so now we're teaching classes here in Visalia once a week on diabetes. But our no-show rate is incredible. People want to know, but just can't get there.

Developing mobile health services may be one of the best ways to ease transportation problems. In the ECV, a mobile clinic travels to farmworker neighborhoods. Local promotoras credit it with involving families in the health care system who would never have otherwise gained access.

Another example is a new mobile clinic just beginning to operate in North San Diego, where farmworkers live in grower-owned or inaccessible areas. The mobile clinic allows physicians and others to provide services to farmworkers at work sites, camps, and other locations. The clinic has faced some difficulty obtaining growers' permission to enter properties. According to one San Diego-based advocacy lawyer, less than a third of the growers have granted access to the mobile unit. Some growers believe that mobile service providers include political advocacy in their outreach activities and consequently refuse to cooperate with the clinic.

Vista Community Clinic in San Diego County has taken a different approach. It staffs a van with a Mexican physician who travels to fields and farmworker neighborhoods and brings selected individuals who need medical care back to Vista's clinics for examinations and treatment. Medical units handle screenings and checkups at farmworker work sites and shelters, while the vans transport only patients who are ill or perceive themselves to be ill.

Inadequate Housing

As described earlier under *Living Conditions*, inadequate housing and other living conditions (including isolated farmworker labor camps, trailer parks, etc.) undermine the health of farmworkers. Public health issues arising from crowded and unsanitary housing conditions and lack of potable water increase the likelihood of the spread of infectious diseases and, given the transnational migration patterns of the population, affect communities in both the U.S. and Mexico. The remoteness of many people's living quarters makes outreach difficult and expensive.

Photo © Jim Bracken

Another access issue related to housing comes from people's need to prove that they are residents of a county so they can enroll in medical support programs. Shared housing means that many farmworkers do not have rent receipts or utility bills in their names. It is common for non-family members to live together, subletting space from another farmworker who pays all the bills in his or her name. Reliable forms of identification that can be used in a variety of settings would help people more readily access systems.

Immigration Status/Fear of Institutions

Fear of the INS, *la migra*, reverberates deeply in the psyche of farmworkers and their families and directly impacts access to care. On a basic level, the presence of INS in areas dominated by farmworker communities, often in the form of INS checkpoints like those in the ECV and North San Diego, hinders mobility. Since immigrant farmworkers must cross such check points to obtain specialty care, they often forego treatment rather than take the chance. A doctor in the ECV said that "at times the INS sets up a road block, which empties the clinic of Hispanics on that day."

In addition, people's fears about *la migra* taint their interactions with other U.S. institutions. Undocumented workers worry that interacting with other institutions will lead to their being deported or will jeopardize their legal standing in the future. These fears influence health education efforts and obstruct continuity of care. For example, promotoras in the ECV report that they must clearly mark their outreach vehicles to distinguish them from those of INS.

The same fears drive farmworkers and their families to seek care across the border; in Mexico, no paperwork is required in order to receive a medical diagnosis and treatment. A practitioner in the ECV has seen the effect firsthand. "They have a fear of government. They are afraid of asking for information and of government knowing what is going on in their home. That's why people go to Mexicali." For undocumented farmworkers, seeking care south of the border involves great financial expense and tremendous risk.

In addition to seeking care in Mexico, people ignore or neglect problems, use home remedies, self-medicate, and perform procedures (such as tooth extractions) themselves . A farmworker's wife in the ECV related a story of her husband's occupational injury, which went untreated until he returned to Mexico. "My husband was accidentally hit in the face with a stick and lost a tooth. He never reported it. He just waited to take care of it in Mexicali."

Legal residents mistakenly fear penalties being imposed on them if they identify themselves or their relatives for use of any social or health service in the U.S. Despite the fact that "public charge" provisions of immigration law apply only to cash payments, people's concerns about possible repercussions inhibit them from applying for noncash benefits.[71]

[71] See INS information at *www.cbpp.org/1-7-00imm.htm.*

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Facilitators/Channels to Health Care

In addition to certain community assets, many outreach workers, medical providers, community leaders, and natural social structures serve to mediate improvements for farmworker health care access. This section highlights those facilitators.

Natural Social Structural Support

Immigrant farmworkers and their families benefit from personal contacts from home and neighboring sending villages for information on meeting the necessities of life in the U.S. Farmworkers who share an area of origin in Mexico tend to live together in the U.S. as well, and these social networks constitute an important source of information and direct help regarding employment opportunities, housing, access to health care, and sociocultural interactions of daily life. The strength of this support system is extremely variable. In general, the more mature, deeply rooted binational networks provide greater support than do newly established ones. The more mature networks often maintain hometown clubs, sports teams, and other means of staying in contact.

Photo © David Bacon, dbacon@igc.org

The extent of mutual help varies from region to region. Farmworkers in North San Diego are the most isolated from people they can trust and under the most constant pressure from INS. This environment particularly hinders newcomers' efforts to find social outlets and peers. Generally speaking, North Tulare has the oldest and most deeply rooted networks, but all of the regions have both newcomer and more rooted immigrant groups in different proportions.

In some areas, hometown associations actually have expanded into multi-county federations of groups of individuals from the same Mexican state or who speak the same indigenous language. *Frente Binacional Indigena Oaxaqueña* (Oaxacan Indigenous People's Front), headquartered in the Central Valley, is one such example. These organizations and associations provide farmworkers with moral support and assistance defending themselves from exploitive or discriminatory actions.

A number of agencies and health networks have recognized this tendency among farmworkers to gather based on mutual places of origin and have established outreach efforts that enhance these natural contacts. Common venues for outreach to farmworkers

include swap meets, parks, laundromats, bus stops, markets, and transportation centers, as well as meetings in their homes and at their work sites. For example, in the Oxnard region, a discussion group composed of Mixteco speakers meets regularly at a local clinic.

Though it is a less personalized form of communication, farmworkers also respond well to public announcements broadcast on radio. A farmworker in North Tulare elaborated on this form of outreach.

> On the radio, they announce a telephone number that you can call if there are any abuses at work. The radio station informs people about the laws. They also give phone numbers to doctors and stuff.

Finally, libraries and school systems are trusted channels through which to reach farmworkers.

Cultural Brokering / Use of Promotoras for Health Education and Prevention

Farmworker informants repeatedly demonstrated a lack of awareness about U.S. cultural norms and available programs, suggesting the need for intermediaries, or cultural brokers, to help them learn about, qualify for, and effectively use health care. Many community members who were interviewed, including providers, had great faith in the promotora model as a solution for outreach to the farmworker community.

The promotora model is a culturally competent method of bringing health education and direct care to people who are otherwise difficult to reach, helping them navigate the system. Individual promotoras typically come from within farmworker communities and can therefore quickly establish trust and rapport.

> *Outreach worker:* People who live in the community and can reach the people and tell them of the services that exist–that is very needed.
>
> *Provider:* Not only do promotoras go door to door to educate people about services, they also set up appointments, help patients fill out forms, and describe eligibility requirements. Some promotoras also give the providers and programs feedback from farmworkers regarding types of services they would like to receive and obstacles to care that they face.

Both of the promotora's roles–health educator and primary care provider–are important in ensuring compliance with treatment and health plans and for effective prevention programs.

Our researchers noted that providers in some areas of the study regions were receptive to and saw the need for promotora programs, but did not realize that such efforts are already under way. For example, a provider in the ECV told an interviewer that "promotoras could be connected to clinics and organizations such as Catholic Charities," apparently unaware that Catholic Charities already has such a program and signaling the need for greater collaboration and information sharing among providers in the region.

Promotora-based Programs

The promotora model has enjoyed success in all four study areas. Though not comprehensive, the following narrative profiles several successful programs in each region.

In the Oxnard area, the major health care networks, religious and social organizations, and church organizations all operate outreach programs directed to farmworker communities. The county's seventy-four public health nurses (four speak Spanish and four translators are available) visit farmworker families in their homes, and local clinics sponsor health fairs and provide medical services. The California Endowment has sponsored a public health employee in the Oxnard region for outreach to the Latino population. This promotora has so far organized three trainings that last six to seven weeks each.

> The trainings involved men and women. Why not address men's issues as well? Because they play a big part in this whole family issue. I believe that knowledge equates wealth. We have forty-six promotoras located in six different cities in Ventura County. Eight of them are men and thirty-eight are women. They are all

One of the promotoras trained through Public Health and based in Santa Paula talked about her involvement.

> I like to help people. I do a lot of work with domestic violence. I refer women to shelters and support groups. Women call me saying their husbands arrived home drunk. The women don't have cars. I arrange to meet them at a central public place. They need someone to listen. They need to know their rights better in a different country.

In the ECV, none of the front line clinics have large outreach staffs focused on farmworkers. Fortunately, there are several nonprofit agencies that make a direct effort to reach out to this population. Several programs based in Indio and Coachella serve farmworkers. Planned Parenthood of Coachella has a small clinic and a committed group of outreach workers who focus on female and reproductive health. These promotoras visit clients in their homes, provide basic health education, and provide translation and interpretation for Planned Parenthood's family nurse practitioner, who travels all over the ECV delivering health services to women. The promotoras follow up with women to make sure they are following their treatment plans. There is also one male promotoro in this program who works with men.

Another outreach program with considerable success in the ECV area is called *Líderes Campesinas*. Through this program, female promotoras offer basic health education and distribute home safety devices, such as smoke alarms, to households. When appropriate, they broach the topic of domestic violence.

In North San Diego, the physical and social isolation of farmworkers increases the need for outreach support from agencies. Promotoras in North San Diego are keenly aware not only of the need but also of the unique challenges inherent in the local environment. These cultural brokers must be able to clearly explain the services available and at the

same time diminish associated fears. Vista Community Clinic, Neighborhood Community Health Center, and Planned Parenthood have all successfully incorporated the promotora model into their outreach and health education efforts. They report that health educators and promotoras visit farmworker sites throughout the week and that mobile units and vans provide medical care to many farmworkers at work and at their encampments on a monthly, biweekly, or weekly basis.

In North Tulare, Family Health Care Network (FHCN) is at the forefront of health education and outreach, and it has also been an innovator in supporting collaboration and public-private partnerships. FHCN's health promotion program employs thirteen staff members who serve its countywide network. They rotate through FHCN clinic sites and offer nutrition counseling individually and educate groups on topics such as diabetes, asthma, prenatal care, sexually transmitted diseases, and childhood obesity. In addition, FHCN employs seven bilingual community outreach workers who conduct home visits to present health information and education. They are certified to enroll individuals in Healthy Families and other programs, which they do by visiting schools, work sites, and Healthy Start centers. These workers display a clear understanding of farmworkers, as evidenced by their outreach strategies, which include attending local swap meets where farmworkers gather.

Kaweah Hospital, with funding from The California Endowment, has been able to partner with FHCN to create and operate a promotora program for culturally appropriate diabetes education. The Diabetes Community Intervention Project (DCIP) adheres to standards set by the American Diabetes Association and targets the underserved Latino population. According to the program's manager, almost all of DCIP's patients are uninsured farmworkers who pay on a sliding fee scale. The promotoras provide services at clinic sites, but most of their work occurs in people's homes. These promotoras, all Latino immigrants who themselves have diabetes, provide support, information, and education through an eight-part program that covers diabetes management, the health consequences of the condition, nutrition, medication, disease prevention, and exercise. The program also involves other family members as caregivers. While the program has not received a formal evaluation, indicators such as levels of compliance with regimens, consistency in meeting appointments, and stabilizing blood sugar levels show its effectiveness.

Tulare County Health and Human Services Agency employs two Spanish-speaking public health nurses whose efforts are focused on prenatal care.[72] The nurses maintain contacts with obstetricians/gynecologists throughout the county and take referrals from physicians. Their services include home visits, referrals to domestic violence shelters and food pantries, and transportation assistance for prenatal care appointments.

[72] Tulare County consistently demonstrates one of the highest teen birth rates in the state according to California Maternal and Child Health Data Book, May 2002, Tulare County.

The study regions demonstrate the wide range of opportunities to which the promotora model is applicable. With proper tailoring to respond to a particular community's need, these models can be replicated widely. A North San Diego outreach worker described why the promotora model is so effective and important.

> The crucial ingredient to successful outreach is to have a bicultural person. Someone who has been in these cultures and who knows the issues. Someone who can approach this population and establish rapport and trust quickly.

Interorganizational Collaboration and Competition

Collaborations and coalitions in health care systems work to the benefit of the farmworker community. It is sometimes noted that "healthy" competition among clinic systems serves to expand health care services. Our researchers observed that those regions that emphasized communication and collaboration across health care systems to pursue common goals were able to maximize services and reduce replication, thereby providing better services to farmworkers. Below, we discuss collaborative experiences while touching on the effects of negative competition in the four study regions.

Effects of Negative Competition

One veteran clinic director explained how only the strong clinics survive in a highly competitive atmosphere.

> There is a lot of competition among the community clinics. The ones that exist are survivors. You have to protect the funding for your area. My attitude is: stay out of my area.

This climate has fostered what have been described by some providers as "predatory" tendencies on the part of more fiscally sound clinics. When a clinic fails, it is taken over by a stronger one. These situations can create tense work environments where management and staff, including physicians, distrust one another, do not communicate effectively, and become polarized.

In another study region, a clinic director, speaking of competition among clinic systems, related how "all hell broke loose" when his organization opened a clinic near a competing system's facility. How an atmosphere of unhealthy competition inhibits service delivery is reflected in the words of a clinic system director in another of the four regions.

> Collaboration between us and the county is definitely a problem. I think we are kind of like Palestine and Israel. I don't know what their problem is. They feel that they should get all the money. I don't think that they could handle all of the patients without us here. I think if the county wasn't there we [the private clinic] would be in the same problem.

Examples of Collaboration

Collaboration and coalitions serve as alternatives to negative competition. They are especially effective when the goals of such efforts are clearly defined. A member of an Oxnard community collaborative described the climate for collaboration. "When there is a good

objective to meet, agencies and organizations work together well. We all attend meetings and recognize the other players. Everyone has their own niche."

Migrant education programs are another example of how agencies can work together to reach farmworker children and their families. Referrals to school nurses are recognized as a common, helpful way to deal with health needs of farmworker children and they can in some cases also reach the children's families. Therefore, school systems collaborate widely with health and social service agencies and with government and law enforcement agencies.

In the Oxnard region, a host of agencies provide social, legal, educational, and advocacy services to farmworkers, and there is significant collaboration taking place among many of their key players. Interviewed representatives of the agencies generally knew each other, and many have been involved directly or indirectly with several different organizations.

San Diego County privatized much of its primary health care service more than a decade ago, and thus there are no full-service county health clinics in the North San Diego region. Without a strong county presence, the task of providing services to the poor falls on nonprofit community health clinics, for which the main challenge continues to be providing services under extremely hard fiscal restraints.

From 1988 to 1994, a migrant services network operated in the North San Diego region. This network, funded by the Office of Community Services of the federal Bureau of Primary Health Care, coordinated health care efforts for farmworkers. It was specifically active in assessing gaps, advocating for better services, and striving to avoid service duplication while enhancing specialization according to agency or organization. It also was involved in training farmworker leaders at encampments and trailer parks in first-aid and in how to respond to emergency medical situations. The program also went by the name Canyon Health Care Coalition because it specialized in coordinating work with farmworkers living in North San Diego's canyons. The network died when Health and Human Services funds were cut. Local providers believe that a reinvigorated version of the network–a staffed umbrella group charged with coordinating the various agencies and the four main clinic organizations–would be most beneficial. Greater coordination would help reduce duplication of services and fill in the current gaps in provider information sharing about farmworkers.

In the ECV, providers are few and competition for clients and grants can be stiff. While some service delivery respondents felt comfortable with the current degree of collaboration, others felt that much more needed to be done. Some providers expressed feelings of being isolated from "mainstream," non-farmworker-oriented care in the area. Another source commented on the issue of patient dumping.

> The other clinics dump cases on the public clinic. The other providers will take a CHDP case and take the money but then refer the case if there are any

> complications. They refer the children because they don't want to or don't know how to take care of the condition.

One collaborator in the area is the Regional Access Project–a health care foundation funded by Riverside County with an annual budget of $1 million–which focuses on improving health care specifically in the ECV. The Regional Access Project has directly supported the activities of *Líderes Campesinas*, Catholic Charities, and the Catholic Church's "Call to Care," a collaboration between the Catholic Church and the county's mental health division.

The ECV also hosts California's only rural empowerment zone, referred to as DACE (Desert Area Communities for Empowerment). This organization is committed to bringing housing, sewer systems, water systems, and other brick-and-mortar elements needed for clinic infrastructure. DACE was responsible for hiring the staff liaison for the community and trailer park owners described earlier. Officials note that DACE is working with Santa Rosa del Valle Clinic, California Rural Legal Assistance, and Rural Community Assistance Corporation in partnerships, in part to train park owners to upgrade units.

North Tulare has several promising collaborations up and running, one of which is the FREE (Family, Resource, Education, and Empowerment) Collaborative. FREE seeks to improve the health of children and families through parent education, training, support, information, and referrals. Funded by Tulare County's Children and Family Commission, the collaborative is comprised of fifty-seven service providers, both county- and community-based, that include health care providers, educators, and family resource centers. Specifically, FREE offers training and certification in parent education, newsletters and other information resources to parents and professionals, and collaboration building. An administrator for the collaborative described its objectives.

> The FREE Collaborative was formed by a group of people with shared interests in providing services to children and families that started to come together with the understanding that we had a lot to learn and share from one another and possibly some advantage could be gained if we were a collective rather than a set of individual programs. The hope was to try to step out of the isolation and fragmentation that is often the case in the social services. In our third year now of meeting, we are definitely moving in that direction.

A primary service is parenting education. A program trainer summed up the program's goals.

> The way we see it is, if there is healthy parenting, then there will be healthy kids. If there are healthy kids, then we have healthy families, which equals healthy communities. That is the whole philosophy of our parenting program.

Parenting classes are offered through collaborating agencies in Spanish and English. The program also identifies parents for training as community parenting educators, who then go out and guide other parents. A program trainer describes the advantages of this internal framework.

> It could be Dona Maria, who has been in Ivanhoe for thirty years and everybody knows that lady, and the parents in the classes are going to want to listen to her . . . Farmworker parents do not want to go to a strange building and say that they have problems with their kids. That is an uncomfortable feeling for the farmworker parents. But if the farmworker parents have someone from their own community that speaks the same language and has been there and done it, I think that more people will open up.

Naturally, at some time or another, collaborations face challenges related to time constraints, member participation, unclear leadership, communication problems, duplicated efforts, resource sustainability, and lack of collaborative skills. Proper training and technical assistance can make a critical difference in the effectiveness of collaborative efforts.

Use of Mobile Clinics

Mobile clinics are an important way to facilitate access to health care by bringing services directly to farmworkers. As described earlier, the North San Diego region is employing mobile health vehicles equipped as full-treatment medical units to deliver health care services to farmworkers, and a community clinic in Vista sends out a van staffed by a Mexican physician to identify people who need care and bring them to the clinics. To build on this effort, grower collaboration is needed. As noted, workers in North San Diego are often afraid to travel to facilities. One grower agreed that mobile clinics are a good idea and work well. He believes that most growers want them, but that there are "just a few bad apples [among growers]." According to some growers, mobile clinics must become more sensitive to work schedules and productivity by arriving at the end of the work day and providing services into the evening.

Photo © David Bacon, dbacon@igc.org

In the ECV, Santa Rosa del Valle Clinic operates a mobile van staffed by a nurse practitioner. Provider and farmworker informants pointed out that this mobile unit was often farmworkers' first introduction to U.S. health care. One farmworker who was relatively new to the area and not yet familiar with available services noted that he did not know about the mobile clinic until he and others saw the van parked at a farmworker trailer park on tribal land every Thursday.

The Oxnard region also has some mobile clinic vans. Samuel Dixon Family Health Center sends one to Rancho Sespe, a farmworker family housing camp, once a month. They provide free vaccinations, blood tests, and other medical assessments. However, there is no dentist or doctor aboard. Arrangements are being made for a van from Clínicas del Camino Real to come to the same camp every two months.

Unfortunately, North Tulare's mobile unit, which was run by Kaweah Hospital with funding from The California Endowment, has been discontinued.

Some providers are concerned that mobile units fragment care and make it difficult to treat chronic conditions. Certainly, mobile services cannot meet all of farmworkers' health care needs. Nor can they operate effectively in isolation from other kinds of providers. Nonetheless, they effectively provide short-term interventions for conditions that otherwise might be ignored and become serious. They are valuable as part of a larger effort to deliver comprehensive care to the farmworker community.

Opportunities for Action

Suggested Program Interventions and Replication of Best Practices

The issue of access to care for the farmworker population–against the many pressures faced by farmworkers, their health practices, and characteristics of the health care delivery system–intersects with a variety of highly politicized issues related to immigration laws, the agricultural food system, and universal health insurance and is entwined with the cultural underpinnings of our society. Such macro-level issues are beyond our reach within this study. But prospects for improvements at the community level clearly exist. Indeed, it may be at the community level that the most compelling arguments and effective pressures for systemic reform are generated.

The program interventions suggested here are a distillation of all of the many comments, ideas, and observations gathered by our researchers from community stakeholders in each subregion on how to address the issue of farmworker health and access to care. Some of the ideas proposed come directly from the communities studied; others are proposed by CIRS in response to information shared by stakeholders. Always the goal is to capitalize on local interests and support.

Despite regional specificities, there are overarching barriers and facilitators related to farmworker health and well-being that are common to the four regions and to California in general. Therefore, our recommendations are constructed broadly, so that they can be tailored and refined to fit the particular context of a given community. Some suggestions are specific to a region or suggest a particular model from one community that could be modified for replication elsewhere. Despite the level of detail provided here, none of these recommendations can be undertaken without extensive community input, participation, and modification.

Summary of Recommended Program Interventions

1. Design and implement one-stop centers.
2. Improve community and provider collaboration.
3. Address housing.
4. Recruit and retain culturally competent health care personnel.
5. Develop effective outreach to indigenous-language populations.
6. Facilitate greater freedom of movement through INS "safe havens" for health care access and recreation in farmworker communities.

Important Elements for Health Services Design and Delivery

Interventions cannot succeed unless the following elements have been considered and incorporated. These qualities and characteristics describe the social and cultural contexts upon which all of our recommendations are based.

- **Anchor Families.** The two main subgroups comprising the farmworker population, anchor families and solo males, have disparate social service needs. Anchor families tend to have young children and therefore require preventive medical care, parenting classes, etc. School-age children can be reached via the schools, as can their parents. In addition, in anchor families women tend to be the main point of contact for brokering the health care relationship for the entire family.
- **Solo Males and Infectious Disease.** Many solo males are young men away from their families for the first time and feel isolated, lonely, and depressed. This subgroup is particularly likely to engage in self-destructive and unhealthy behavior such as substance abuse and unsafe sexual activity. In addition, solo males tend to live together in high densities, lending to transmission of infectious diseases such as tuberculosis. Programs such as mental health support and infectious disease education and prevention must be tailored to the specific needs of this subpopulation.
- **Income Fluctuation / Medi-Cal Eligibility / Continuity of Care.** Farmworkers suffer from low hourly wages and insufficient annual hours to produce a livable and stable income. Medi-Cal and other programs that require quarterly requalification fail to take these annual income fluctuations into account, creating situations where farmworker families only qualify for support programs for parts of a year, resulting in discontinuity of care.
- **Value of the Settled Farmworker Population.** The farmworking population is incorrectly viewed as predominantly migrant, when in fact about one-half are permanently settled. This figure increases if shuttle migrants, who are based in one place in California for long periods each year, are factored in. Most California farmworkers have a home base in one place in California. Those who are settled can play key roles as conduits of information to newcomers.
- **Binational Program Coordination / Provider Training.** It is possible to identify the towns and villages that supply farmworkers so that health programs in the U.S. can be designed and implemented in coordination with those in sending areas. This would help front line U.S. providers understand how farmworkers seek services. For instance, in the ECV, collaboration between practitioners in Mexicali and Coachella should be further investigated, and provider training about health care in a binational context should be offered to both.
- **Word-of-mouth Approaches.** Because farmworkers tend to rely on human relationships rather than formal institutions, word of mouth is often an essential means of communication. Programs that emphasize peer communication and education and are given ample time to reach deeply into a community are likely to have greater success than those that make use of written outreach materials.

Radio broadcasts may also be effective as a medium for health education, as many farmworkers listen to Spanish-language programs.

- **Capacity Building in the Farmworker Community.** Farmworker leaders represent key contributors to improving the health and well-being of communities where they live and work. These people already volunteer at their children's schools, serve meals at local senior centers, mentor youth, and participate in local political efforts, but outside of the farmworking community they often feel powerless because they cannot speak English and lack experience with bureaucratic and political processes. Capacity building programs would strengthen the latent skills of these individuals, transforming them into effective envoys of the farmworker community to local agencies and community organizations.

- **Schools as Facilitators and Brokers for Health Services and Information.** More attention must be given to the role of schools in providing services to children and linking adults to the services they need. Schools appear to be one of the few U.S. institutions that immigrant farmworkers generally trust. Given that comfort level, efforts should be made to further access farmworking families using schools as a reliable conduit for information sharing and health education.

Photo © David Bacon, dbacon@igc.org

- **Grower Participation.** Growers and grower organizations must also be involved in efforts directed at improving farmworker health care delivery. Our research indicates that many growers do not currently allow mobile units or outreach worker vans on their properties, preventing direct delivery of services. It is essential that service providers, outreach workers, and others come to mutual agreements with growers. Once a trusting rapport is established, more challenging topics, such as shared cost of health insurance, should be broached.

Recommendations

1: Design and implement one-stop centers

The one-stop concept aims to reduce time, distance, and other obstacles that currently impede farmworker access to needed treatments and thereby increase the population's participation in comprehensive quality care.

An approach that has been well received by service and health professionals, as well as by the farmworker community, is development of one-stop centers that either directly provide or facilitate people's access to health and other correlated services, improving the likelihood that they will take advantage of the help available to them. Based on our findings, farmworker communities would greatly benefit from one-stop centers that are tailored to fit the needs of each community but that generally encompass education, information, referrals, and, where necessary, actual provision of health services.

Maximum community input is essential in setting one-stop center programming. Input should come not only from farmworkers but also from community groups, private foundations, public service agencies, elected officials, and other stakeholders who can play key roles in crafting the center's services and building additional community momentum. A community-based approach would address many of the primary concerns and suggestions expressed by both farmworkers and community members during the study. The following list is not comprehensive, but it gives insight into the broad spectrum of programming options to be considered and tailored for each community.

- Education (ESL, GED, citizenship).
- Case management (formalized cultural brokering).
- Practical referrals / specialist care at one-stop centers.
- Legal advice and representation (immigration assistance).
- Identification cards for undocumented workers (for cashing paychecks and opening bank accounts).
- Nutrition education and information about where to obtain emergency food.
- Dental care.
- Mental health services/activities (dealing with substance abuse and domestic violence).
- Health care with continuity for widespread chronic health problems (diabetes, high blood pressure, asthma, arthritis, permanent injuries).
- Pharmacies for filling prescriptions and receiving consultations on proper use of medications.
- Transportation to the center.
- Advocacy to enhance skills needed to interact with landlords, foremen, and health and social service agencies.
- Affordable child care.
- Housing information and resources.

- Translation services for non-Spanish-speaking indigenous-language people.
- Job training for farmworkers and their families in the health care field.

With appropriate community involvement, the one-stop center concept can be customized to meet the specific needs of a subregion or of an even smaller community within a subregion. For instance, in the Oxnard region, it is critical that a one-stop information center emphasize the needs of the hard-to-reach indigenous-language population. In North San Diego, the community must take into account the high proportion of solo males and the dearth of safe, adequate housing.

In Context: One-Stop Centers in the ECV

Currently in the ECV, there is already significant political and institutional will behind the one-stop center concept. The Desert Areas Community Empowerment Zone and Riverside County are sponsoring construction of a health service center near Mecca and supporting the creation of a smaller one in Oasis. In addition, Coachella Valley School District is planning to build a large K-12 school complex that could serve as another one-stop center. Construction of necessary roads, sewer facilities, potable water supplies, and other elements will be financed largely with public funds. Beyond the physical infrastructure, however, the type and approach to programming must be carefully considered to make sure that any health care and associated support services offered at the centers meet the needs of the population. In this particular region, such centers must offer direct health services, including primary, urgent, preventive, specialist, and mental health care, rather than just information, because of the long distances farmworkers must travel, the lack of public transportation, and the total lack of specialty care near farmworker enclaves.

Suggested Characteristics of One-stop Centers in the ECV

Transportation. Transportation is the highest priority for the ECV's farmworker population scattered throughout the region in trailer parks, apartments, homes, and homeless camps. Many farmworkers are isolated during the day, and in some regions, public transportation systems cannot reasonably meet demand for this widely dispersed population. A van that circulates among the communities could deliver people to one-stop centers.

Culturally-sensitive Specialist Care. Providing specialist care is the second priority. Cardiologists, ophthalmologists, rheumatologists, podiatrists, endocrinologists, and others should have scheduled visits at the centers weekly or biweekly. This would allow primary care providers to consult with them and to interpret treatment options to the patient (since specialists rarely speak Spanish). Medical assistants and others could be enlisted to translate and interpret and to encourage patients to follow recommended treatments.

Child Care. One-stop centers must provide onsite child care so that parents can attend to sick relatives or receive treatment themselves.

(continued)

In Context: One-Stop Centers in the ECV *(continued)*

Supplemental Health Services. Centers could offer a range of supplemental services that are currently needed and underutilized by the community–mental health, alcohol and drug treatment, enrollment assistance, and others–preferably through routine weekly or biweekly visits similar to those suggested for specialty care.

Expanded Use of Promotoras. Providers need intermediaries on their staffs who can act as liaisons between farmworker families and health systems. The centers should be supported by an expanded promotora or intermediary staff. Promotoras who visit homes are crucial for getting people into the centers for care, making sure they keep their appointments, and promoting compliance with treatments.

Urgent Care Center. Including a twenty-four-hour urgent care center at the Mecca clinic would expedite treatment and relieve already overburdened centers at JFK Hospital in Indio and at Moreno Valley Community Hospital.

Health Education. One-stop centers should also provide effective health education and parenting classes. A health education program could include support groups organized by town of origin, health condition, or other factors. These could be led by providers or by health educators.

ESL Training. One-stop centers should provide training in English as a second language (ESL) coupled with vocational training for positions in health care that could help people transition from farmwork to better paying jobs while populating the health care industry with bilingual Spanish speakers. In the ECV, the county's Economic Development Agency already has a start-up program along this line that could serve as a template for other efforts.

Living Wages and Professional Development. High turnover and low wages for medical and nurse assistant staffs require constant recruitment of new bilingual employees. Wage and other incentives (such as job training) should be created to retain staff and help them advance within their fields to build a cadre of culturally competent, bilingual professionals.

2: Promote and support collaboratives

In each study area, some form of collaboration or coalition exists that is seeking to address problems shared by various health organizations in the region. Community members would like to see additional coordination specifically focused on issues faced by the farmworking population.

Provider Collaboration

Almost across the board, providers and other service personnel suffer from a lack of coordination of services to the farmworker community. Many providers believe that greater coordination would help reduce the duplication of services that currently exists. For example, instead of efficiently dividing efforts geographically, some region's clinics currently each send outreach workers to the same work sites, trailer parks, and encampments. Many outreach providers complain that they cannot easily provide someone in need with access to more appropriate services from other clinics.

Another problem stemming from poor coordination is that best practices and successful strategies are not shared among providers. In particular, there are not enough formal means of providing cross-training among those who are in direct, daily contact with farmworkers. Greater coordination could eliminate the duplication and expand and improve services.

Beyond Provider Coordination: Communitywide Collaboratives

Other community stakeholders expressed a need for a collaborative focused specifically on farmworker health that gathers together representatives from all groups involved. The reasons behind the need for greater collaboration have already been enumerated. Following is a list of the types of community representation necessary to ensure broad representation.

- Farmworkers as active members with farmworker leaders who are compensated for their more extensive roles, giving them financial freedom from field work.

In Context:

Provider Coordinating Umbrella Organization — North San Diego

Among all providers interviewed in North San Diego, there was strong interest in cooperating and collaborating. But, in the course of busy days, these good intentions fall victim to economic constraints, organizational agendas, and the demands of carrying out an individual's organization's mission–growing food, treating illnesses, providing shelter for the homeless.

As described in this report, a migrant services network previously developed an effective model for coordination of health care efforts for North San Diego farmworkers. Providers indicated that while the network existed there was more cohesion in farmworker health service activities, which allowed for greater focus and improved delivery.

A foundation- or community-sponsored collaborative based on the migrant services network model in North San Diego could provide a structure within which providers could share information, marshal resources more effectively, expand services, and eliminate duplication. In other words, information exchange at all levels would, in itself, transform the face of health care for farmworkers in the San Diego study region.

- Watchdog agencies and labor unions that advocate for farmworkers and Spanish-speaking populations.
- School systems, which have a proven track record for both serving children and linking adults to services via their children.
- Community college representatives who can make campuses central meeting points for mobile health units, flea markets, etc. at low cost.
- Representatives from churches and spiritual communities and organizations.
- Growers and members of the agricultural industry.
- The Mexican Consulate, who can work to influence policy to resolve international economic, social, and governmental issues.
- Representatives of government labor agencies and the county agricultural commission.
- Established community groups.
- Local political leaders and Native American tribal leaders.
- Housing developers.

While each collaborative must develop its own agenda, we offer the following suggestions provided by community members.

- Facilitate and promote an environment for fruitful cooperation between various public and private providers in the area to fill in the gaps in care.
- Oversee creation of a universal, effective, simple referral process that would be adopted by all providers and health systems in the area.
- Conduct a communications campaign to increase the visibility of farmworkers and public awareness of their working and living conditions.
- Engage the grower community in arriving at a mutual agreement allowing for better outreach and delivery of services to farmworkers where they work.
- Assist in developing and implementing an outreach strategy targeted at reaching indigenous-language populations.

In North Tulare, agencies and organizations have already forged collaborative partnerships to improve the health of the farmworker community. These efforts demonstrate the capacity and readiness among private, public, and nonprofit sectors to work together to achieve goals that would not be possible without joint endeavors. Some success has occurred in coordination of services, but higher levels of collaboration require significant trust, resource sharing, and cooperative allocation of service specialties. These investments can generate large rewards, with organizations working together in a manner that increases the capacity of each while achieving a common goal.

Without technical assistance and support, collaborative partnerships will find it difficult to reach their goals. Members want to work collaboratively, but many lack the skills and

knowledge needed to proceed. An external organization with expertise in capacity building could teach a range of technical skills, helping collaboratives to:

- Develop a mission and vision and set clear, specific objectives based on community determined goals.
- Build communication and understanding between collaborative members and identify mutual goals and interests.
- Gain conflict management and resolution skills to maintain a climate of cooperation.
- Plan, design, and implement programs.
- Link with outside groups that hold common goals and interests to enhance available financial, information, and other resources.
- Create mechanisms for evaluation and accountability so that members of collaboratives can constantly refine and innovate based on lessons learned.

3: Address housing

Currently, many farmworkers in the study regions live in deplorable conditions, not only in flimsy substandard structures but even in fields and in holes in the ground.

The need for safe, adequate, affordable housing for farmworkers is an issue throughout the state. While some regions experience this problem more acutely than others, housing remains a pervasive challenge that directly impacts farmworkers' mental and physical health and their ability to access care.

The quality of farmworker housing cannot be improved overnight. However, living conditions can be improved quickly in areas where the problems are severe, as in the case of the spider holes of North San Diego, for example, by fairly simple short-term interventions. Such interventions are necessarily highly specific to individual areas, but examples include distributing handheld water filters to residents of crude camps that lack potable water and training outreach workers in basic first-aid so they can help prevent and control infections among injured workers who live in unsanitary conditions.

Interventions to improve the quality of farmworker housing require a longer term approach. We recommend the following actions.

- **Address regulatory and other obstacles to improved living conditions.**

  Though state law allows for construction of farmworker housing on agricultural land, local laws in some counties do not. The cost of fighting lawsuits that result from conflicts between these laws is prohibitively expensive for most farm owners. In addition, county regulations typically impose expensive fees, so that very few growers can afford to build needed housing. Those who have prevailed against such obstacles have done so only after considerable investment. Farmworkers would benefit from reconciling these conflicts. Counties could also build momentum for improving farmworker housing by offering interested growers legal assistance and other resources as they approach the regulatory environment.

- **Expand the number of intermediaries for county loan programs.**

  Many counties offer loan programs for improving housing. More often than not, however, such programs are difficult for farmworkers to understand, and more individuals are needed to help explain and enroll people. These additional intermediaries should be based in the community and could work for a nonprofit organization in the area. In the ECV, the county has a staff of intermediaries who train new applicants to the program, and the Compadre Program, currently run by the Desert Areas Community Empowerment Zone, employs an additional intermediary. This effort should be expanded within the ECV and replicated elsewhere.

- **Extend county loan programs to tribal lands.**

  In areas like the ECV and North San Diego, where Native American tribal land is the site of farmworker housing, county loan programs should be extended to include tribal lands. Some of the worst conditions are found there, in part because they lack building codes.

- **Promote development of ordinances for tribal lands.**

  Tribal lands often do not have ordinances governing housing, sewers, water, and other health issues, and those that do lack enforcement staff to ensure compliance. Where necessary, tribal governments should be given resources to help them design ordinances that bring standards on tribal lands in line with similar county requirements. They also need resources and training for enforcement staff to ensure compliance with the new ordinances.

The lack of Spanish- and indigenous-language-speaking providers is an insidious barrier to effective diagnosis and treatment.

4: Recruit and retain culturally competent health care personnel

Increase the Number of Appropriate Health Care Workers

Providers identified significant challenges in recruiting and retaining health care personnel, despite Health Professional Shortage Area designations that authorize funding, loan repayment, training, and other incentives to attract primary care, mental health, and dental personnel to these areas.[73] Shortages span all health professions–primary care physicians, specialists, public health nurses, mental health therapists, health educators, and outreach workers. Both public and private service providers further recognize the importance of services that are culturally appropriate to the farmworker community. Various agencies and organizations in each region have demonstrated success in health promotion efforts, outreach activities, and mental health counseling. For example, service providers employ staff members who originate from farmworker families; these individuals include outreach workers, case managers, health promoters and educators, clinic receptionists, and patient care staff.

Farmworkers particularly need Spanish-speaking clinicians. Providers report that low compensation and the demands of serving large numbers of uninsured clients hinder

[73] Office of Statewide Health Planning and Development, Primary Care Resources and Community Development Division. Each region has received a designation in at least one category, and some are designated for all three.

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In Context: The Oxnard Region's Indígena Community Organizing Project

Despite its limited resources, the Oxnard region's Las Islas Family Group has made great strides in the county in attempting to address the needs of Mixteco and other indigenous-language people from Mexico. It is estimated that at least 5,000 and perhaps as many as 20,000 people in the county speak Mixteco as their primary language.

A family nurse practitioner at Las Islas is very involved in the effort to expand health care and social services to this group. She, along with a native Spanish-speaking public health nurse who works for the county's public health perinatal services, was instrumental in starting the Indigena Community Organizing Project in January of 2001. The project is specifically geared to addressing the multiple barriers the Mixteco/indigenous-language population face in accessing health care.

For the group's first meeting, the organizers obtained a translator from California Rural Legal Assistance to interpret between Spanish and Mixteco. This arrangement developed into a collaboration between the two groups that also helps people address job-related issues and obtain documentation from Mexico for those who have no legal document from any country.

The clinic continues to hold a well attended monthly meeting called *Reunión Indigena.* Las Isla's full-time Mixteco translator described the practical issues dealt with during these meetings.

> We have a meeting here for solo men and families the last Saturday of the month. The meeting lasts for two hours. We talk about obtaining birth certificates, going to the hospital for emergencies, getting Social Security numbers for their children, and diseases like tuberculosis. People find out about the meetings from flyers and by word of mouth. This community is very united. They talk to each other at work, where they live, and at the clinic. This meeting provides one of the few outlets for solo men and others in the community to relieve their sense of isolation.

The meetings also provide a forum for people to get information about occupational safety and health issues, tenants rights, nutrition, and immunizations.

their ability to attract such personnel. Local programs focused on identifying and attracting Spanish-speaking, culturally sensitive health care personnel, particularly physicians, are fundamental to maintaining quality of care for farmworkers in all four regions.

Educate and Inform Current Physicians

Farmworkers uniformly described physicians as lacking knowledge about their cultural beliefs, values, and practices. One response to this concern would be to improve the level of cultural competence among physicians. A cultural competency program would teach providers about the demographic, income, and living conditions in the community and would further address employment, migration and settlement patterns, and their experiences with and attitudes about health systems in both countries.

Launch a Local Initiative to Recruit New Service Personnel and Train Existing Staff

- Increase hiring of translators and cultural go-betweens such as outreach workers and promotoras for particular programs.
- Actively recruit Spanish-speaking medical personnel, including dental care workers.
- Recruit medical personnel from Mexican medical and dental schools.
- Provide training for physicians, nurse practitioners, and physician assistants in the medical approaches and beliefs of Mixteco and other indigenous-language Mexican groups. Involve medical and dental associations in this training for providers and involve professionals from Mexico.
- Strengthen programs that employ the promotora model.
- Provide living-wage salaries and family health benefits for social service and outreach workers.

The cultural experiences of indigenous-language people from Mexico are profoundly different from those of Spanish-speaking immigrants.

5: Develop effective outreach to indigenous-language farmworkers

All four of our study areas and many regions of California face the additional challenge of providing services to indigenous-language peoples from Mexico. As an underclass of Mexican society, these people are doubly isolated from our institutions. Their numbers here are growing, and therefore there is an urgent need to develop outreach programs that will, over time, gain momentum and build trust with these exceptionally vulnerable groups. Elements of an outreach campaign could include the following.

- Implement standard procedures in front line clinics that provide simple, clear, unthreatening instructions and messages.
- Incorporate attention to the "look" and "feel" of health care delivery systems to make them culturally appropriate.
- Support health care orientation programs at one-stop information centers that are geared to hard-to-reach populations.

- Advertise widely that services are available to all and that minimal identification is required.
- Emphasize personal contact and visits to communities in which farmworkers live.
- Develop an identity among social workers and promotoras as advocates.
- Support grass roots and community organizations that have established programs for education and access to services.
- Adopt a long-term view that allows enough time for word of mouth to promote services and encourage their use and for the community to build trust.
- Provide video materials on safety and health in indigenous languages to address the lack of written language and high illiteracy rate.

Access to health care is critically impaired when people cannot freely travel to and from and attend clinics and other facilities.

6: Facilitate greater freedom of movement through INS "safe havens" for health care access and recreation among farmworkers and their families

In all the study areas and particularly in North San Diego, many undocumented workers cannot access health and recreational services because they risk being apprehended and deported when they do. There is an urgent need for measures at the community level to facilitate greater freedom of movement for farmworkers and for those who provide them with health care.

Growers' political advocates have succeeded in establishing cultivated fields as legally off-limits to enforcement by INS. In other areas of the country, employers exerting informal pressure on INS have also obtained relief from their interference at employment sites. Similar limits on INS activities could be defined to protect the health care rights of undocumented immigrant subgroups.

The climate of fear inspired by INS activities must be directly addressed by engaging INS staff in an ongoing conversation about the critical importance of farmworker access to health care and recreation. Our observations and study in the four regions profiled suggest that lack of access to health care and recreational opportunities creates a public hazard. Infectious diseases spread rapidly when people are not familiar with or allowed to use preventive measures and cannot access health care systems for diagnosis and treatment. Originally minor conditions, left untreated, escalate to emergencies that create added financial burdens for hospitals and other institutions. The near total isolation of some groups of farmworkers in areas where INS activity is pervasive leads to situational mental health problems, which in turn lead to antisocial and sometimes criminal behavior.

- Create a recognized safe haven around health care facilities and recreational activities and publicize this policy in farmworker communities to improve utilization of clinics and significantly impact public health in the area.

- Help concerned citizens exercise community political will in an organized fashion by contacting INS regional representatives to discuss ways of reducing the harmful impacts of INS activities, particularly the tendency of such activities to discourage farmworkers from obtaining health care.

Successful county efforts could be replicated in other communities. Though we believe the most effective approach is one grounded in the particulars of each community, over time it is possible that the positive momentum gained from local efforts could bring statewide acceptance of a safe haven plan and even help set INS regional policies in California.

Final Thoughts

Farmworkers, who create the wealth of California's $30 billion agricultural industry, are a constantly disposed of, impoverished population. Males typically come years before their families, causing social problems of isolation and difficulties when the families are reunited. Housing and working conditions have not improved in decades, leaving a demoralized population with an enormous rate of turnover. Service delivery, although improved from earlier periods, still has left the vast majority of farmworkers and their families marginalized from U.S. institutions. The state that imports this disadvantaged working class cannot avoid the social costs of its maintenance and reproduction. For this reason, we need to investigate how to improve conditions for these workers and their families.

The Agricultural Workers Health Study research, upon which this report is based, grew out of the need to enrich somewhat limited insights into farmworker health gained by statewide sociological studies such as the NAWS, CAWHS, and BFHS. We saw that there was a cultural interrupt between Mexican immigrant farmworkers and the U.S. institutions seeking to help improve their health. The statistical information from the previous surveys could not by itself deepen understanding of this difficult relationship and point to ways to bridge the gaps in service delivery and communication. By examining the difficult relationship between farmworkers and institutions in a series of local contexts, the Agricultural Workers Health Study has unearthed those details in the words of participants. It is our hope that philanthropic and government institutions planning interventions in the regions we have studied will look carefully at these findings.

The Agricultural Worker Health Study deepened previous work by carrying out several hundred open-ended interviews with participants of all types. Still, by embarking on an open-ended study that covered many aspects of farmworker life, from living and working conditions to specific health problems, we could not delve into areas as deeply as we wished. Our assignment was to profile the landscape of farmworkers and the providers that serve them in specific geographic regions. Those parameters required us to keep a broad focus. However, the data we collected, complemented by the survey research already gathered, will allow us to identify the specific research questions needed to continue a more detailed search for understanding of the explicit barriers and facilitators to farmworker well-being.

The next step is to follow up on those specific research questions with ever more focused methods.

CALIFORNIA INSTITUTE FOR RURAL STUDIES

Appendix A

Common Terms and Acronyms

AWHS – Agricultural Workers Health Study, conducted by the California Institute for Rural Studies in connection with The California Endowment's Agricultural Worker Health Initiative, profiling the issue of access to care in six California regions through the eyes of community stakeholders. This report is based on four of the six profiles.

BFHS – The Binational Farmworker Health Survey.

CAWHS – California Agricultural Workers Health Survey.

CHDP – Child Health and Disability Prevention program.

CRLA – California Rural Legal Assistance.

Culture-bound Syndromes – Illnesses experienced by rural Mexicans that are unrecognized by the western medical establishment, such as *nervios* (nervousness), *empacho* (digestive upset), and *susto* (fright).

DCIP – Diabetes Community Intervention Project.

ECV – East Coachella Valley, one of the four subregions profiled.

EPA – Environmental Protection Agency.

ESL – English as a Second Language.

FQHC – Federally Qualified Healthcare Center.

GED – General Education Diploma.

HMO – Health Maintenance Organization.

HUD – U.S. Department of Housing and Urban Development.

INS – Immigration and Naturalization Service under the U.S. Department of Justice.

NAWS – National Agricultural Workers Survey, conducted by the U.S. Department of Labor.

NDIC – National Diabetes Information Clearinghouse.

OSHA – Federal Occupational Safety and Health Administration.

Shuttle Migrants – Shuttle migrants live part of the year in their home village or town in Mexico (some live in Texas) and migrate to California for the farm season. This group is comprised of both families and solo males.

Solo Males – Farmworkers who are unaccompanied at their current residence by a spouse, child, or parent. About half of all farmworkers fit this description.

UFW – United Farm Workers.

WIC – Women, Infants and Children, a food subsidy program.

Appendix B

Research Methods

This report is based on findings from four of the six subregions investigated in the Agricultural Workers Health Study (AWHS). Initiated in September 2001, the AWHS strives to take an in-depth look at the health care delivery systems in these subregions, summarizing opinions and facts given by communities of farmworkers, of people in charge of delivering services to farmworkers, and of other observers concerned with farmworker issues. The recommendations and observations presented reflect a consensus in the community as mediated by the researchers.

While this report, due to confidentiality restrictions, cannot provide the specificity that was achieved in the reports upon which it is based, it is important to explain the methods used by the AWHS research team.

Methodological Steps

The approach of the AWHS study is open-ended questioning of subjects with an emphasis on collecting details on the particular problems and issues important to the respondent, while balancing this with a systematic collection of information across sites.

The first step was to organize a telephone survey of the provider and service community. Separate protocols were designed for medical providers, social workers, and outreach workers. This facilitated identification of the main neighborhoods where farmworkers live and fairly detailed descriptions of the main programs that provide services to them. The telephone inquiry, which involved conversations with scores of people in the four study areas, did not allow an assessment of the strengths and weaknesses of the service resources available to farmworkers. And, of course, it did not allow farmworkers to identify their major health concerns and describe the primary barriers they face in obtaining services.

Next, the research team implemented one protocol for farmworkers and another for providers and others in the community. Interviewers carried out close to one hundred in-person interviews and a handful of focus groups per region and attended a series of community meetings and events under the guidance of Principal Investigator Richard Mines. The interview selection process endeavored to capture major networks of farmworker individuals. However, due to the vast distances involved for some study areas, the choice of individual farmworkers did not focus entirely on networks; geographic representivity was also a goal. The selection intentionally included people of different ages, men and women, and people separated from and with families. Indigenous-language

peoples were also targeted. Interviewers intentionally followed up on issues that the community (from all sectors) identified as crucial to farmworker health. As a result, they spoke to community organizers, educators, community leaders, and outreach workers of various kinds. In addition, they were careful to sample all types of health care providers, such as nurses, mental health professionals, intake workers, administrators, doctors, and patient care associates. The interviewers were successful in obtaining interviews with some individuals in each of the organizations considered to be front line groups delivering services to farmworkers.

The interviewer/analysts wrote up the interviews as field notes. The interviews were all either recorded or translated into extensive notes. In many cases, the entire interview was transcribed. But, in part due to the difficult circumstances of some interviewing situations, interviewers sometimes summarized parts of interviews and included direct quotes of choice comments of the interviewees. Translation was done largely by the interviewer/analysts, each of whom is fluent in Spanish.

The next step was to import the field notes (in Microsoft Word) to a qualitative text analysis software package (Atlas.ti). This process necessitated revision and editing of the notes, which are edited only with difficulty once they are in Atlas. This task created the opportunity to also review notes and extract contacts and leads for subsequent field work in the subregion. Standards on the format of written notes were established.

The AWHS team employed codes to facilitate the systematic analysis of field notes (by means of Atlas). Codes are concepts that are represented in the interview data. Each code was defined to ensure inter-coder reliability. The code list in its categorized form is also useful for conceptualization of the model to be used to explain how to improve outreach to farmworkers. The code lists were further refined by piloting the coding, as described below. The creation of new codes arising from the data was not inhibited, but procedures were set up to guide their creation. In other words, codes were added during the coding process.

With the completion of data collection in one study area and before commencing another, protocols were re-examined and possible coding schemes were reviewed. The examination of the field notes is serving to facilitate the iterative refinement of the protocols and research design.

Coding

The interview data were placed in "text with carriage returns" format. These are called primary documents (each interview = a primary document) and are considered the data source. A set of primary documents comprises a hermeneutic unit. Within a hermeneutic unit, subsets of primary documents can be grouped into families. The families in the farmworker subset include sex, age, farmworker insurance status, documentation status,

health condition diabetes, place of origin, and household composition (family versus solo male). The families for health providers and others include sex, age, bilingual ability, organizational type (public versus private), administrator, health care personnel, and outreach worker.

Three hermeneutic (analysis) units were created–one for farmworkers, one for health care providers/outreach workers, and one for all other respondents for each area. The primary documents were coded using the code lists. Coding consisted of selecting a phrase, sentence, paragraph, or group of paragraphs that represented a concept. The selected texts are called quotes. Multiple coding was allowed and has served to facilitate analysis of the data.

Analysis

After coding was completed, data queries of codes were generated showing the quoted text for each corresponding code. Quotes associated with the codes were printed to identify themes, patterns/relationships, and dimensions of phenomena (valence) and to provide contextual understanding. Analysis of families allowed for a richer comparison of concepts by varying categories of respondents, such as public versus private health providers and insured versus uninsured farmworkers. These data queries on codes and their corresponding quotes were used to structure the report. Feedback on these analyses was given to current field researchers so they could further revise protocols and sampling.

Reinforcing our primary data, the analysts used many documentary sources, including census data, surveys, other secondary studies, and local and state statistics.


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