

The Agricultural Worker Health Study

Case Study No. 5: Salinas Valley

A baseline report of
The Agricultural Worker Health Initiative

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June 2003

Research conducted by



Sponsored by
The California Endowment



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Summary of Main Findings

Population and Environment

- The Salinas Valley is known as the “Salad Bowl of the World.” It is at the heart of Monterey County’s \$3 billion agricultural industry, which supplies consumers throughout the U.S. and more than fifty nations with one billion pounds of fruits and vegetables.
- An estimated 68,000 farmworkers comprise the workforce driving this industry. With an estimated 54,000 accompanying family members, Monterey County’s farmworker population is the third highest in California, following Fresno and Kern counties.
- The vast majority of farmworkers in the region are from Mexico, principally from the highland states of Guanajuato, Michoacan, Jalisco, and Oaxaca. Most have limited education, literacy, and English skills.
- The majority of farmworkers in the Salinas Valley are married. Many men have left their wives and children behind in Mexico. Some of the men who do live in the valley with their families follow the crops during the winter, leaving their wives and children in the Salinas area.
- The number of indigenous-language farmworkers in the study region has been growing in recent years. These immigrants are typically more recently arrived, and they present needs and beliefs that are profoundly different from those of Spanish-speaking farmworkers. In particular, most speak little English or Spanish, come from very impoverished backgrounds, and have little or no experience with formal health care and social service systems.

Living and Working Conditions

- Salinas farmworkers labor under difficult conditions, including long hours stooped over and exposure to heat, cold, pesticides and dangerous machinery.
- Compensation for agricultural labor in general is low. Farmworkers interviewed in the study reported wages of approximately \$7 per hour. Most find only intermittent employment, despite the region’s long growing season, resulting in a median income of just \$11,000 per year.
- With the exception of foremen and unionized workers, few farmworkers enjoy health insurance or other benefits, such as vacation or sick days.
- The cost of housing in the Salinas Valley is high with limited vacancies. Overcrowding among farmworkers is subsequently rife. In addition, many are forced to reside in substandard shelters, including garages, shacks, and sheds that often lack running water and electricity.

Health and Social Service System

- A fairly extensive network of public, nonprofit, and for-profit providers offer culturally and linguistically appropriate primary care services for farmworkers. A



number of the for-profit providers in the study region that serve farmworkers offer sliding fee scales and payment plans for uninsured patients.

- Most of the area's providers offer bilingual services.
- Clínica de Salud del Valle de Salinas, which operates seven primary clinics in the valley, is the largest provider of primary care services to farmworkers. Other providers include the county's public clinics and medical center, Mee Memorial Hospital and its two outpatient clinics, and Salinas Valley Memorial Health care system, which runs a hospital and a clinic in Salinas.
- A parallel network of traditional healers provides ethnospecific health care to farmworkers, who see these providers because they feel they are more effective for certain conditions and because their services are generally less expensive than those offered at clinics.
- Clínica de Salud is the main provider of dental services for farmworkers in the Salinas Valley and the only one that serves people without insurance. The other major provider is the Appolonia Foundation, a nonprofit organization offering dental services to children and pregnant women throughout the valley. Drs. Sanger, Stewart, Chiang, Morris, and Murillo run the only private pediatric dental practice in the Salinas Valley that accepts patients with Medi-Cal. There is a shortage of Spanish-speaking dental workers regionwide.
- Access to mental health services is much more limited than access to either primary or dental care. Only Monterey County and a limited number of nonprofits offer mental health services to patients who do not have Medi-Cal or private insurance, and many farmworkers rely on priests and pastors for counseling. The shortage of Spanish-speakers is most severe in the mental health field.
- Existing mental health services are geared towards the seriously and persistently mentally ill, rather than toward those suffering from situational depression, anxiety, and stress, the conditions most frequently identified among farmworkers.
- Salinas Valley social service providers address a broad range of issues, including youth programming, housing, substance abuse, domestic violence, reproductive health, and HIV/AIDS prevention and treatment. Most offer services in Spanish, and a number of programs specifically target farmworkers.

Principal Health Conditions

- The principal chronic conditions reported by Salinas farmworkers and providers are diabetes—which has risen significantly in recent years, particularly among youth—and upper respiratory disease, hypertension, and obesity.
- Salinas farmworkers suffer from numerous occupational health problems as well, including musculoskeletal injuries, arthritis, cuts and lacerations, sprains, pesticide-related conditions, and injuries from accidents associated with heavy machinery and vehicles.
- The majority of farmworkers suffer from poor dental health. Screenings of children under age five reveal that two in three have some degree of dental disease and that one in five suffers from severe dental problems.
- Mental health concerns are common among farmworkers and their family members. Traumatic experiences crossing the border and difficult living and working conditions in the U.S. can lead to stress, anxiety, and feelings of isolation.

Substance abuse, domestic violence, gang activity, and high rates of teen pregnancy are some of the consequences of a lack of attention to these situational mental health conditions.

Barriers that Impede Access to Care

- Lack of insurance and inadequate insurance coverage coupled with the high cost of treatment, diagnostic exams, and medications are the principal barriers to care. In addition, private providers often do not accept Medi-Cal insurance, particularly for mental and dental health services, which further limits access to those forms of care.
- Services in the region, particularly those provided by specialists, are concentrated in the city of Salinas, creating a significant barrier for residents of southern Monterey County, especially for those residing in outlying towns and labor camps that are not served by public transit.
- Farmworkers often avoid applying for public insurance coverage and other entitlements because of the complex paperwork and documentation required, requirements for periodic reapplication, fears of being apprehended by INS, and misunderstandings about “public charge” laws that can threaten their attempts to become legal residents.
- Barriers imposed by field work include lack of sick pay for workers who need care, workers’ lack of personal transportation from the fields to appointments, and the fact that clinics typically operate only during traditional business hours.
- Language barriers include the often limited literacy and English-speaking ability of farmworkers and their families and the difficulty providers have recruiting and retaining bilingual, culturally competent staff. For people who speak indigenous languages, this barrier is acute; there are virtually no translators or established programs or materials in their native languages.
- Common farmworker living and working conditions—long field hours, crowded residences, limited and shared kitchen facilities, and poverty—make it difficult for people to implement preventive behavior, including regular exercise and healthy eating habits.

Facilitators to Access to Care

- Cultural brokers and peer networks, including friends, relatives, coworkers, *mayordomos*, and others, provide farmworkers with vital information about life in the U.S., including available health and social service resources and how to gain access to needed services.
- The *promotora* system is growing in the Salinas Valley and has been instrumental in transmitting health education messages and helping farmworkers access available resources. These health promoters are current or former farmworkers who are intimately acquainted with the community’s approaches to health care and with the barriers people face in accessing care and implementing preventive measures.
- An impressive number of providers in the Salinas Valley speak Spanish and are familiar with farmworkers’ health-seeking beliefs and practices. Many of these individuals go to extraordinary lengths to ensure that patients receive needed care.



Menu of Community-based Options

- Improved access to primary health care via additional education about supplemental programs that cover patient expenses; expansion of health promotion activities, including mobile clinics serving residents of outlying communities; improved transportation to specialized care in Salinas, increased case management programs to improve continuity of care, and support for innovative health outreach and education, particularly in indigenous languages.
- Increased access to health insurance via support for public/private partnerships that provide farmworkers with health insurance, efforts to increase the number of eligible individuals who access Medi-Cal and Healthy Families, education regarding “public charge” issues, and funding for clinic employees who would specialize in accessing pharmaceutical company’s free/low-cost medication programs.
- Better support for programs that help farmworkers take advantage of subsidized housing programs, for tenants’ rights organizations and development of “just cause” eviction laws, and for emergency rent and utility assistance.
- Improved access to mental health services, including support for additional free and low-cost mental health counseling for farmworkers and non-counseling options such as recreational opportunities, workshops, support groups, co-counseling, respite care, and mental health promoters.
- Greater occupational health and safety via outreach and education for farmworkers to help them identify and report health and safety violations, recognize the responsibilities of growers, and assert their right to designate a doctor for Workers Compensation reviews.
- Improved cultural and linguistic competency among providers via mechanisms that attract and retain bilingual and bicultural providers, increase training for health promoters, support policy efforts to allow Mexican health care providers to work in the U.S., and increase access to trained medical interpreters in both Spanish and indigenous languages.

Introduction

The purpose of this assessment is to provide The California Endowment (TCE) with a profile of farmworkers in the Salinas Valley subregion, which lies within Monterey County. The assessment focuses on several key dimensions and generates a menu of potential community-based approaches for improving farmworker health care. This analysis is intended to assist TCE in developing a place-based strategy of intervention in this subregion as part of its Agricultural Worker Health Initiative.

This is the fifth in a series of Agricultural Workers Health Study (AWHS) reports profiling and assessing farmworker health care delivery in several agricultural subregions of California. Each subregion roughly encompasses a commuting area in which farmworkers travel to and from their residences, work, and health service delivery areas. Within each region, there is a community of professional and volunteer health care and social service providers who know each other and the communities they serve and who share common goals. Furthermore, farmworkers in an area tend to come from a few common communities of origin in Mexico. Many farmworkers maintain contacts within their original communities and with their colleagues in other parts of California and the U.S., creating an information network that spans subregional boundaries. By working within a geographic area, we can define the farmworker community and health care delivery systems available to them in detail. This targeted analysis allows us to identify specific problems and design effective solutions. TCE has defined each subregion to comprise a relatively cohesive unit with unique health care and institutional problems.

The AWHS utilizes a case study approach. The main subject of the inquiry is barriers to and facilitators of health care delivery as utilized by this subregional population, both in and out of the immediate area. Documentary review, participatory observation, and interview techniques were used to identify barriers and facilitators and ways to improve delivery. A telephone survey of service providers in the area was conducted, as were in-person interviews with representatives of providers, the communities, and, most importantly, farmworkers. Through these methods, many sources of information were marshaled to arrive at the full story. (See Appendix for details on methods.)



Background

The Salinas Valley supports a \$3 billion agricultural industry that supplies the U.S. and fifty other countries with a billion pounds of fruits and vegetables each year.

The Salinas Valley

The study region is composed of the Salinas Valley, which lies between the Gabilan and Santa Lucia mountain ranges in Monterey County, extending along the Salinas River from the city of Salinas in the north to the southern reaches of the county near the hamlet of San Ardo, south of King City.

Approximately 200,000 people reside in the study region. The city of Salinas, by far the largest population center in the region, is home to about 150,000. The remaining towns lie south of Salinas along Highway 101 and are all much smaller. From north to south are Chualar, Gonzales, Soledad, Greenfield, and King City, which range in size from 7,525 (Gonzales) to 12,583 (Greenfield). Further south still are several small, isolated hamlets, including San Lucas (population 419) and San Ardo (population 501).

The Salinas Valley is known as the “Salad Bowl of the World.” Its fertile soils and temperate climate support a \$3 billion agricultural industry, supplying consumers in the U.S. and more than fifty countries with a billion pounds of fruits and vegetables. The valley

produces 34 percent of California’s vegetable crops, supplying half of the nation’s broccoli, cauliflower, spinach, and strawberries, 80 percent of its lettuce, and 85 percent of its artichokes. In addition, Monterey County has become a major producer of premium grapes, with more than 40,000 acres of wine grapes. Farmers in the region earn average revenue of more than \$12,000 per acre, compared with \$112 per acre for wheat.¹

Field crops are grown in the flat, central part of the valley, while vineyards are cultivated on the foothills flanking the valley’s western and southern borders. Organic production, at more than

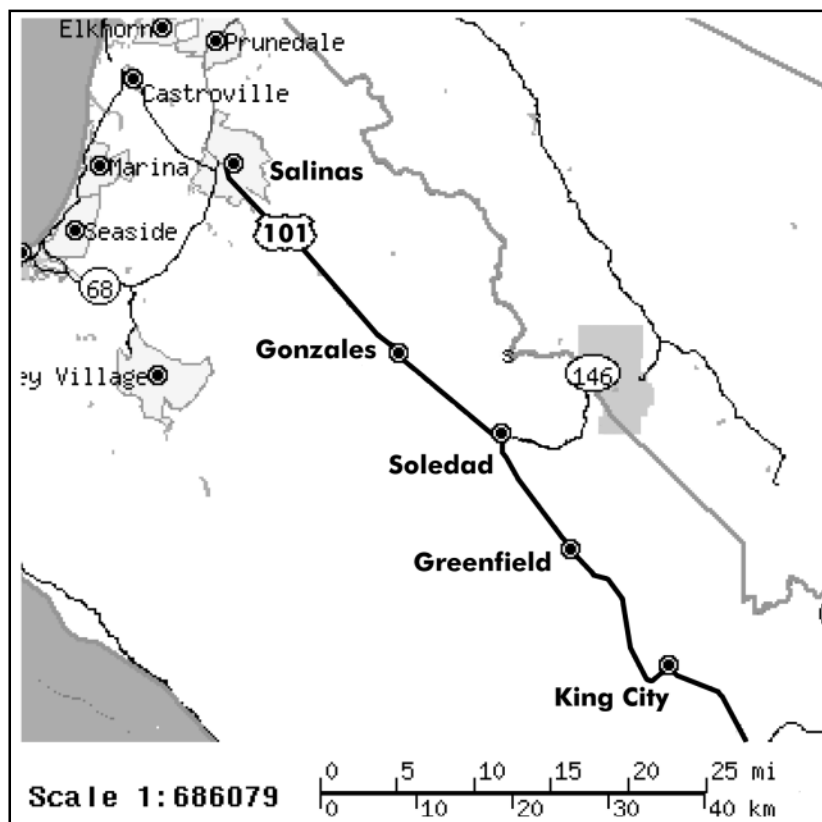


Figure 1. The Salinas Valley

Source: U.S. Census Bureau, Geography Division, Cartographic Operations.

¹ Hukill, Planet Earth: The Gift of Salinas Valley Soil, p. 17.



4,000 acres, is expanding and has been incorporated into the holdings of most large companies.

According to the 1997 U.S. Agricultural Census, there are about 1,200 farms in Monterey County with an average size of 1,277 acres. The area supports both small farms and large commercial operations, including Dole, Tanimura & Antle, and Driscoll, that employ thousands of farmworkers directly or through farm labor contractors.

Farmworker Demographics

Overall Population

There are an estimated 67,700 farmworkers in Monterey County, with an additional 53,800 accompanying family members,² making Monterey County's farmworker population the third largest in California after Fresno and Kern counties. According to the 2000 U.S. Census, the valley's principal cities, all of which have large farmworker populations, grew by an average of 37 percent between 1990 and 2000, nearly three times the rate of both Monterey County and California overall.

Monterey County ranks third among California's counties for the size of its farmworker population, which exceeds 67,000.

Greenfield as a Proxy for Salinas Valley Farmworker Characteristics

Reliable demographic data specifically describing farmworkers are difficult to obtain. This study relies primarily on two sources: the Farmworker Housing and Health Assessment conducted by Applied Survey Research (ASR) in 2001 and census data for the town of Greenfield, which was chosen as a proxy for the region because of the high percentage of farmworkers living there.³ We can extrapolate information regarding the general characteristics of farmworkers and their families from these sources. Nonetheless, it is important to recognize that data sources inevitably undercount undocumented, solo male (men who have no accompanying spouse, child, or parent), and migrating members of the farmworker community (farmworkers who travel between two or more geographic areas during the farm labor season, following the crop cycles).

The town of Greenfield has a large farmworker population. Almost half of its residents were born in Mexico.

Age, Gender, and Household Characteristics

Nearly half of Greenfield's total population—as counted by the census—was born abroad, almost entirely in Mexico. The population is young, with a median age of twenty-four, significantly lower than the California median age of thirty-three years. Two in five (42 percent) of the city's residents are nineteen years or younger, compared to 30 percent for the state. At the other end of the spectrum, just 4.9 percent of the population is sixty-five

² Larson, Migrant and Seasonal Farmworker Enumeration Profiles Study—California.

³ Year 2000 census data indicate that 88 percent of Greenfield's population is Latino and that 48 percent of its population works in agriculture. In light of routine census undercounting of both farmworkers and Latinos, we can assume that the percentage of farmworkers in Greenfield is in fact higher.



or older, compared with 10.7 percent of California’s population, reflecting the tendency of retired farmworkers to return to Mexico.

Nearly three-fourths of Greenfield households include children under the age of eighteen, nearly double the rate of 40 percent for California. A similar number (71 percent) of

households include a married couple. Average family size is large—4.83 overall (compared with 3.43 for California)—and the average size of families living in rental units, as most farmworkers do, is 4.93, nearly double the California average of 2.79.

Males comprise about 53 percent of Greenfield’s adult population.⁴ Solo males often live with established families who are relatives or old

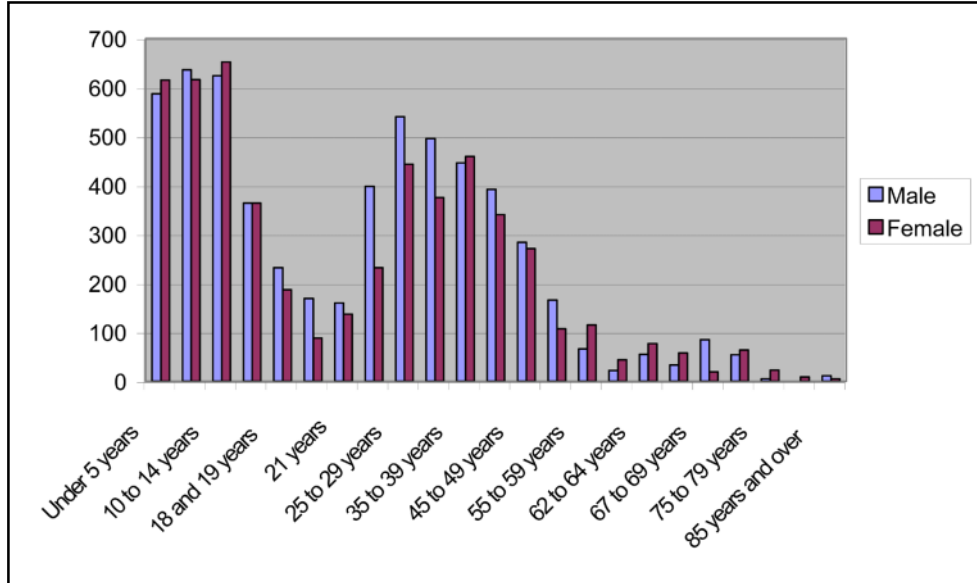


Figure 2. Greenfield Residents Grouped by Age and Gender

Source: U.S. Census Bureau, 2000 Census.

The average size of families living in rental units in Greenfield is almost double the California average.

friends. Many also share motel rooms or apartments with other solo males, often in very crowded conditions. The tendency of solo males to live in camps and crowded together in rental units leads to their numbers typically being undercounted in census data. Still, the data clearly indicate that males predominate in the twenty-one to thirty-nine age range. In addition, the census reveals that the city of Salinas has the highest male-female ratio—114 males for every 100 females—of U.S. cities with populations of more than 100,000.⁵

In sum, farmworker settlements, as reflected in Greenfield, are composed of large households where most of the adults were born in Mexico. The population is young due to the large number of children, the large number of young solo males, and the fact that farmworkers often return to Mexico when they can no longer withstand the hard physical labor associated with fieldwork.

⁴ These differences are also reflected in the demographics of ASR farmworker survey respondents: 56 percent were male and 44 percent were female.

⁵ U.S. Census Bureau, A Census 2000 Profile of Gender in the United States.



Language, Education, and Income

Fluency in English is vital for immigrants' success in transitioning to life in the U.S. According to the census, the vast majority of Hispanic respondents in Greenfield had extremely limited English skills. Some 63 percent reported speaking English "less than very well" and an additional 24 percent spoke no English at all. Similarly, 63 percent of students in Greenfield Union Elementary School District were classified as "English learners" during the 2000-01 school year.⁶

Most farmworkers have had few years of schooling. According to the census, nearly 70 percent of Greenfield's adults do not have a high school degree. Surveys of current farmworkers consistently reveal a median educational level of less than seven years.⁷

As a consequence, providers cannot rely on printed materials for successful education, prevention, and outreach efforts. Instead, they must employ more expensive—and therefore less accessible—audiovisual means. In addition, farmworkers often find it difficult to read and understand instructions and indications associated with medication and are intimidated by the paperwork associated with applying for health insurance and other public entitlements.

Many farmworkers come to this country to give their children a good education and consequently a better life. California Department of Education data suggest that those educational goals are difficult to realize, in part due to children's limited English skills. In Greenfield Union Elementary School District, for example, 69 percent of seventh grade "English Learners" scored "below basic" or "far below basic" on the language arts section of the Standardized Testing and Reporting (STAR) exam, while 58 percent scored similarly on the math component of that exam.

Failure in school can lead to adult lives of poverty. Although most of these children do not become farmworkers, they tend to take low-paying service-sector jobs. Low educational levels further deprive their communities of an essential resource—bilingual and bicultural professionals who can provide desperately needed advocacy, health care, education, and social services.

The incomes of some 17 percent of all families in Greenfield and 25 percent of those with children under the age of five fall below the poverty level. In California as a whole, only 11 and 19 percent of the same families live in poverty. Farmworkers in California report annual family household incomes of \$7,500 to \$10,000.⁸ Those figures are corroborated by ASR findings for the Salinas Valley, where farmworkers reported a median family income

The California State Department of Education found that some 87 percent of Greenfield's residents speak little or no English.

⁶ California State Department of Education.

⁷ See Rosenberg, et al.'s findings from the National Agricultural Workers Survey (NAWS), Suffering in Silence, the Binational Farmworker Health Survey (BFHS), and the Immigrant Voice Survey.

⁸ Rosenberg, et al., Who Works on California Farms?



of \$11,000. The U.S. Census reports per capita income of about \$9,000 in Greenfield, whereas in California the per capita average is approximately \$23,000.

In Greenfield, women head 13 percent of households, 65 percent of which include children and almost 30 percent of which report incomes below the poverty level. The number of female-headed households earning less than the poverty level increases to 35 percent when the family includes children under eighteen and rises to a staggering 45 percent when the family includes a child under age five. Among all households in Greenfield, 26 percent of children under the age of eighteen live in conditions of poverty.

Another indicator of the prevalence of low-income families in the study region is the proportion of children eligible for free or reduced-price school lunches. According to the California Department of Education, 72 percent of all students in Greenfield Union Elementary School District were eligible for such meals during the 2000-01 school year, significantly more than were eligible in California overall, 47 percent.

Many of the Salinas Valley's newly arrived Oaxacan immigrants are settling in neighborhoods on the north side of Salinas.

Places of Residence and Origin of Salinas Valley Farmworkers

In the city of Salinas, the majority of farmworkers live on the east side. North Salinas is beginning to develop a significant concentration of farmworkers as well, mostly in the Santa Rita neighborhood and the area near Northgate Mall. Recently arrived indigenous-language speakers from Oaxaca are settling mostly in these northern neighborhoods. The rest of the towns in the study region are predominantly populated by farmworkers.

Quantifying the places of origin of Salinas Valley farmworkers proved difficult. Our informants were mostly from four Mexican states—Guanajuato, Michoacan, Jalisco, and Oaxaca. The ASR study reported additional significant populations from Zacatecas and, surprisingly, the Mexico City area.

Indigenous-language Populations

The majority of farmworkers in the Salinas Valley are Mestizo—individuals of mixed-race origin—whose primary language is Spanish. In recent years, however, the face of the farmworker population in the valley has been changing, due to an influx of Mixteco, Triqui, Zapotec, and other indigenous-language populations from the Mexican state of Oaxaca. Informants estimate that there are approximately 15,000 indigenous-language immigrants in the Salinas Valley, or 13 percent of the farmworker community. The sending networks from Oaxaca are relatively new and are much less established than older networks from other parts of Mexico, such as Michoacan.

The culture, beliefs, and experiences of indigenous-language immigrants are profoundly different from those of Spanish-speaking Mexicans. The majority are young, come from deeply impoverished backgrounds, are very poorly educated, and have little to no



experience with formal health care systems. Most have limited English and Spanish skills, and there are no trained interpreters or providers who speak their languages.

Indigenous people face severe discrimination in Mexico, and those patterns are replicated in the U.S., where virtually all *mayordomos* are Mestizo. Informants note that discrimination, coupled with a reputation for not complaining or refusing any work, often results in indigenous-language farmworkers being assigned the most onerous and dangerous tasks in the fields. Informants also note that women suffer from particularly low status, even within their own culture, making their lives especially difficult.

People who speak indigenous Mexican languages face discrimination in both Mexico and the U.S.



Analysis of Key Dimensions

Farmworker Living Conditions

Housing in the Salinas Valley

According to both farmworkers and provider informants, housing is one of the most severe and intractable issues affecting the health and well-being of farmworkers in the Salinas Valley. Housing is in short supply, terribly expensive, and often dilapidated and dangerous.

Census data for Greenfield indicate that, unlike other California subregions, a relatively small number of farmworker families in the Salinas Valley live in mobile homes and trailers—just 2.8 percent (6.8 percent according to the ASR study). Among farmworkers living in permanent structures, 27.7 percent reported living in houses, 54.9 percent in apartments, 4.4 percent in motel rooms, 2.9 percent in garages, 2.7 percent in rented rooms in boarding houses, and 0.2 percent in storage sheds. Another 0.2 percent are homeless and live in cars. Informants report that some migrants live in even worse conditions—including tents, caves, and even holes dug in the sides of ditches—with no electricity or running water.

Housing costs in the Salinas Valley have increased dramatically in recent years. According to the National Home Builders Association's Housing Opportunity Index,⁹ the Salinas Metropolitan Statistical Area earned the dubious distinction of being the least affordable housing market in the United States, with less than 8 percent of homes affordable to families earning the median income of \$53,800 during the first quarter of 2002. Nationwide, 65 percent of homes are affordable to median-income families. Earning on average just \$11,000 a year, few farmworkers can afford to buy a home without a considerable subsidy.

According to the director of an affordable housing nonprofit, people who otherwise qualify for subsidized home loans often find themselves excluded as credit risks. Purchasing a car on credit or co-signing a family member's loan, for example, can result in a family failing to qualify for a home loan. Despite these challenges, some extended families have succeeded in buying a home by combining members' incomes. This is a positive step for these families, albeit one that results in many individuals sharing a two- or three-bedroom house.

Rental properties are expensive as well. Census data reveal that about 25 percent of households in the Salinas Valley paid more than 35 percent of gross income for rent, a figure

⁹ http://www.nahb.org/assets/docs/files/Complete_byRank_813200283807PM.xls.

The Salinas Metropolitan Statistical Area was named the least affordable housing market in the U.S. in 2002.

that increased in all Salinas Valley cities between 1990 and 2000 (see Table 1). ASR respondents reported spending 47 percent of their incomes for housing.

Making matters worse is the short supply of available rental units. Many informants commented on seeing farmworkers with babies and small children going door to door in search of garages and other substandard forms of shelter to rent. Informants also noted that some families stay in the valley during the winter despite being unemployed rather than give up what housing they do have.

Overcrowding

Overcrowding, which the census defines as more than one occupant per room, is rampant among farmworkers. Census data put the proportion of units that are overcrowded in Monterey County as a whole at 21 percent. That figure climbs steeply when predominantly Latino and farmworker communities such as Gonzales and Greenfield are analyzed, as shown in Table 2. ASR's survey identified 32 percent of respondents as sleeping in living rooms, dining rooms, and halls. Others who reportedly lived in residential structures actually slept in outbuildings such as garages and storage sheds.

Solo males, particularly migrants following the harvests, often rent single motel rooms for a group (a provider cited as many as forty men renting one room). In these cases, workers often sleep in their cars and use the motel room for showering and changing clothes. An interviewer described her perceptions of a motel room shared by three workers.

Rent at the Greenfield Inn is \$180 per week, which is split between three men (i.e., \$240 a month to share a room with two others). The room is not equipped to handle the three men living there. There is only enough room for a twin mattress next to the wall. The motel provides a TV and they bought their own miniature refrigerator. The men worked it so the TV was on top of the refrigerator, and the water cooler was on top of that. To the right of the refrigerator was a small couch. There is a staircase of about ten stairs that seems to lead to a loft

Table 1. Percent of Households with Gross Rent Greater than 35 percent of Household Income

	1990	2000
Gonzales	19%	23%
Greenfield	19%	22%
King City	14%	22%
Salinas	19%	23%
Soledad	8%	28%
Monterey County	21%	25%

Source: U.S. Census Bureau, 2000 Census.

Table 2. Percent of Salinas Valley Residents Living in Overcrowded Conditions (1.01 persons or more per room)

Gonzales	53%
Greenfield	54%
King City	40%
Salinas	33%
Soledad	41%
Monterey County	21%

Source: U.S. Census Bureau, 2000 Census.



where all I could see was another mattress and a heating lamp. Right underneath the staircase, to the back, there is a tiny bathroom with barely enough room for the sink, toilet, and a shower. Underneath the staircase, the men had made their own pantry and kitchen, using propane tanks for cooking.

A farmworker living in a labor camp outside of Soledad described living arrangements that are typical in camps. “Our little apartment has two rooms, a bathroom and a kitchen. There are nine of us living there. I sleep on a pull-down bed in the kitchen.” An interviewer for this study noted similar conditions in a Soledad apartment.

A young farmworker in Soledad invited us into his apartment. He shares a tiny two-bedroom apartment with his brother and four other friends. Two of them sleep in each of the bedrooms, while two sleep in the living room. . . . The apartment was in a state of disrepair—the walls were cracked, light fixtures didn’t work, and the refrigerator wasn’t functioning properly.

A health care provider offered another example of deplorable living conditions among farmworkers. “Housing is a serious problem here. I had a patient last year who had twin preemies and was living in an unheated garage. That’s obviously not good for the mother or the babies.”

A farmworker in a labor camp outside of Soledad shares a two-bedroom apartment with eight other men.

Substandard Living Conditions

Many apartments in the study region are in a state of disrepair. Numerous ASR respondents reported health and maintenance problems in their dwellings, including roaches (57 percent); cracked, peeling, or chipping paint (46 percent); drafts and holes in windows (42 percent); leaking faucets or plumbing (42 percent); heating problems (30 percent); leaking ceilings (18 percent); insufficient water supplies (15 percent); and exposed sewage (6 percent). However, given the lack of “just cause” eviction laws in Salinas and the limited number of rentals available, tenants are often reluctant to complain. Code enforcement is a double-edged sword; the process of relieving people from unsafe and unsanitary living conditions may lead to people being displaced from the only shelters they have. Watchdog and housing groups report that they are reluctant to seek enforcement of codes because it can result in more people being homeless.

Health Risks Associated with Poor Living Conditions

Crowded conditions create not only stress but also public health problems that put both farmworker families and the general public at risk. Communicable diseases can spread easily in such environments, as noted by a physician in Salinas.

We see a lot of . . . communicable diseases at this practice. TB [tuberculosis] is increasing due to substandard housing and the fact that many people are living together in overcrowded conditions.

Another health care provider described overcrowding and its consequences.

You can find six to eight people living in a small garage, or twenty people in a two-bedroom apartment. That can lead to respiratory infections, hepatitis, and other infectious diseases.



Inadequate housing leads to social problems as well. Boys often escape the claustrophobic environment at home by spending much of their time on the streets, where they can fall prey to gangs, violence, substance abuse, and problems with the law. However, parents are more likely to restrict girls to the house. Trapped in overcrowded apartments, they may experience depression and anxiety, as a mental health provider explained. “Density and overcrowding can lead to familial stress. Kids have no space of their own, so where do they go? Boys go to the street and cars, but girls have nowhere to go.”

Children’s school performance also suffers when they have no place to study, do homework, or even leave their books and materials, as the director of an affordable housing agency in Salinas explained.

People can’t advance under deplorable housing conditions. In order for services to be effective, people need to live in a stable housing environment. For example, there are a lot of kids with no room of their own, who sleep on the couch in the living room. Those kids need their own room, with a desk to study at.

Some informants also reported a high risk of sexual abuse of children generated by parents who must rent rooms to relatives or strangers in order to make ends meet.

Crowded conditions where multiple families share small apartments make it very difficult for farmworker children to get adequate privacy, sleep, and study time.

Working Conditions in the Salinas Valley

Employment and Earnings

Thanks to the area’s temperate climate, with relatively cool summers and mild winters, the Salinas Valley growing season extends from March into November. An estimated 67,700¹⁰ workers spend some part of the year working in agriculture in Monterey County, where the demand for labor ranges from a high of 44,000 work slots at peak season to a low of 22,000 during winter months.^{11,12}

Some growers in the Salinas Valley raise similar crops in Huron, California, and in Yuma, Arizona, during the winter. Work is also available in the southern California regions around Coachella, Oxnard, and Santa Maria. Farmworkers following those harvests can obtain more than eight months of work a year. However, those assured such out-of-county employment are a distinct minority.¹³

¹⁰ Larsen, Migrant and Seasonal Farmworker Enumeration Profiles Study—California.

¹¹ California State Employment Development Department.

¹² A large segment of the workforce consists of short-term workers, such as women with children and recent arrivals, who work for short periods during the year and share or alternate in the job slots available to them. The total number of farmworkers present in the region is subsequently greater than the 44,000 employed at peak season.

¹³ There are no accurate data on out-of-county movement for the Salinas Valley. Statewide data from the National Agricultural Workers Survey consistently show that less than 15 percent of the labor force follows the crops within the U.S. to make a living.



Informants report migratory workers are mostly men who leave their families behind in the Salinas Valley for the winter. There is conflicting evidence on the number of people who follow the crops. The Migrant Profiling Project¹⁴ reported that 46 percent of Monterey

County farmworkers are migrants and that 23 percent of their family members accompany them.¹⁵ On the other hand, only 19 of 495 individuals surveyed in the ASR study (4 percent) reported leaving the area to work. The truth no doubt lies somewhere between these starkly different portraits of migration among Salinas Valley farmworkers.

Farmworker employment is best described as intermittent or occasional rather than as full time or even part time. In Greenfield, the unemployment rate is 13.4 percent. However, more telling is the

Table 3. Work Status of the Latino Population Age Sixteen or Older in Greenfield for 1999*

Number of Weeks Worked	Males	Females
50 to 52	29%	18%
48 to 49	10%	6%
40 to 47	18%	9%
27 to 39	11%	18%
14 to 26	15%	16%
1 to 13	7%	9%

* Data for individuals who typically work full time, defined as 35 or more hours per week.

Source: U.S. Census Bureau, 2000 Census.

variation in number of weeks worked per year. As Table 3 shows, only 39 percent of male and 24 percent of female Hispanics in Greenfield worked full time for eleven months or more during the year. The true figures are probably lower still, given census undercounts of the farmworker population.

Farmworker employment is best described as intermittent. Few immigrant workers find full-time year-round jobs.

California Employment Development Department (EDD) data indicate an average hourly wage of \$8.54 for farmworkers in the Central Coast Region during June, 2002.¹⁶ Similarly, 2001 Occupational Employment Statistics (OES) data indicate a median wage of \$8.60 per hour for farmworkers in the Salinas Metropolitan Statistical Area.¹⁷ It is important to note, however, that these sources cite employer-reported figures. The majority of farmworkers interviewed for this study reported wages of \$7.00 per hour, with wages of

¹⁴ Larsen, Migrant and Seasonal Farmworker Enumeration Profiles Study—California.

¹⁵ According to the U.S. Dept. of Health Services, Health Resources and Services Administration (HRSA), migratory agricultural workers are “individuals whose principal employment is in agriculture, who have been so employed in the last twenty-four months, and who establish for purposes of that employment a temporary abode. Seasonal agricultural workers are individuals whose principal employment is in agriculture but who do not migrate.” U.S. Dept. of Health Services, Main Glossary of Terms.

¹⁶ California Employment Development Department, The California Agricultural Bulletin, <http://www.calmis.cahwnet.gov/FILE/AGRIC/2002-06ag.pdf>.

¹⁷ [http://www.calmis.cahwnet.gov/file/occup\\$/oeswages/SALIsaes2002.xls](http://www.calmis.cahwnet.gov/file/occup$/oeswages/SALIsaes2002.xls).



up to \$12.00 per hour for piece work. The system was described by a young worker from Oaxaca.

Right now, I work by piece work. We pick celery as a team. We're paid \$1.40 per box. At the end of the day, we divide the number of boxes by the number of workers and that's how we get paid. When the work is good, we can earn about \$90 for a ten-hour day.

The number of acres of vineyards in the Salinas Valley has increased in recent years, a positive development for farmworkers, who generally prefer vineyard jobs because they are less arduous and because they offer more year-round work. A young farmworker confirmed this. "I work in the broccoli from March to November and then in grapes from November to March. Working grapes is much easier than working broccoli. I get fat when I'm working in grapes." Unfortunately, only a minority of workers is able to obtain employment in the region's vineyards.

Physical Working Conditions

Common problems associated with field work include pain and injuries from bending and lifting, insufficient and/or unsanitary bathroom facilities and water supplies, and long hours worked without breaks, all of which are detrimental to farmworker health.

Many farmworkers suffer from musculoskeletal pain and injuries from spending long hours stooped over and from lifting heavy items. Crops such as strawberries and lettuce are particularly hard on the body, as they grow close to the ground and entail many hours of working bent over. Foot problems are commonly reported due to standing in the fields all day, and sprains result from falling or tripping in the fields, especially when the terrain is muddy.

Arthritis and joint problems are among the most commonly reported occupational complaints. Farmworkers tend to believe that these ailments are due to work in wet and cold conditions.

Working in broccoli affects your knees. They water the broccoli and it's waist high, so you're walking in water up to your waist. You spend the day cold and wet because the leaves are wet. You get *reumas*/pain in your knees because they're wet. A lot of people are afraid of broccoli because of the pain it causes in your knees.

The issue is exacerbated by growers who do not supply farmworkers with proper clothing and protective gear, as a farmworker explained.

Some farmworkers don't have the money to pay for the plastic boots they need to protect themselves at work. If they don't use boots, they get wet, and then they have to spend all day wet. Before, they used to give you all that, but now you have to buy it yourself. The pants alone can cost you up to \$30.

While most growers appear to be complying with regulations that require portable bathrooms at the fields, getting permission to use them can be another matter. Many

Agricultural work all too often involves difficult field conditions—excessively hot or cold weather, damp or flooded fields, and long hours stooped over low-lying row crops.



farmworkers complain that foremen refuse to grant breaks because it slows down the work. In addition, when portable bathrooms are available, they often are not cleaned or supplied regularly and do not include water for hand washing. A female farmworker noted that “sometimes we’ll hold it all day because the bathrooms are so dirty.” A foreman also reported that “one thing I’ve seen in almost every place I’ve worked is that the bathrooms are very dirty.”

Though foremen now more consistently provide drinking water and toilet facilities in the fields, they do not necessarily grant workers time to make use of them.

Farmworkers complain that drinking water often runs out during the day, contributing to cases of heat stroke and dehydration. In addition, water is frequently distributed through shared jugs or cups that encourage transmission of infectious diseases.

Farmworkers report considerable pressure to work long hours, at a fast pace, and regardless of illness or injury. For some, this is a matter of keeping their jobs, while for others it is a question of not losing income. A woman who had recently undergone gall bladder surgery, for example, did not tell the *mayordomo*/foreman about it because she feared he would not allow her to work. Another described pressures from foremen and co-workers to continue working despite a need for medical attention.

Workers feel pressure from the companies and other co-workers to not take time off to get medical attention. If you take time off, you disappoint the company and your team members. It’s difficult to find a good team, and when you get a good one, it only takes one absent worker to throw off the labor. I’ve heard my own parents say how they don’t want to let the team down.

The system of labor and payment itself can actually undermine supervisors’ efforts to protect their crews, as one farmworker explained.

While we are paid \$7 per hour, we get additional pay for the boxes. So though the *mayordomo* tells workers not to carry too many boxes at once, or that boxes should be carried by several people, workers continue to carry too many boxes by themselves in order to make more money.

Treatment on the Job

Agricultural employment in California is dominated by crew systems and farm labor contractors. The foreman usually hires, trains, supervises, and disciplines workers. Foremen often also find housing for their workers, provide transportation to work and other services (often for a fee), and help orient newcomers to life in the U.S. Foremen report directly to growers or, increasingly, to farm labor contractors. Some farmworkers described supervisors who treat them well, while others complained of poor treatment and lack of respect, which can create significant stress. According to one farmworker,

I suffer from *nervios* [stress] because of the way the supervisors treat people. The supervisors will sometimes treat you badly, just so they can look good with the boss.

Surveys have demonstrated that foremen working for contractors tend to provide lower wages and less frequent work and are more commonly guilty of mistreating workers by charging or overcharging for equipment, food, rides, and other services and by under-



reporting hours and paying workers less than promised.¹⁸ One farmworker described the problem succinctly.

Before, the company paid well. Now, what the company pays stays with the *contratista* [contractor]. The *contratistas* pay the workers less so they can make more money for themselves. And *contratistas* never offer health insurance.

Several providers reported that sexual harassment against women in the fields is a common problem. Harassment of women stems principally from foremen who use threats of retaliation to obtain sexual favors. California Rural Legal Assistance (CRLA) recently won a major lawsuit against a grower for sexual harassment of female workers. Gay farmworkers may also suffer harassment and discrimination. A foreman who had a gay worker on his team reported that several other workers exhorted the crew boss to fire “*ese pinche joto/ that damn fag,*” which he refused to do.

Occupational Health and Safety

Farmwork is widely considered one of the most hazardous occupations in the U.S. According to the Occupational Safety and Health Administration (OSHA), agriculture has risen during the past twenty years from the third to the first most hazardous occupation in the country.¹⁹ Still, in farmworker communities, occupational health and safety issues generally do not receive the same attention as chronic health conditions such as diabetes and hypertension, perhaps because they present less of a financial burden to health care systems. As noted by the director of CRLA, “occupational health issues often get swept under the rug in light of primary care access issues. However these issues are equally, if not more, important and should get equal footing.”

Farmworkers, for whom job security is rare, are understandably reticent about demanding appropriate attention when injured. Informants noted that communicating to supervisors about on-the-job injuries can jeopardize their jobs and/or their incomes.

A few days ago I got hurt at work. I fell off the lettuce machine and hurt my ankle and my lower back. I didn’t report anything, because if you do, they’ll make you work light duty²⁰ and they’ll only pay you \$5.25 an hour.

Farmworkers report that foremen often pressure people on light duty to quit. For example, they require people assigned to light duty to come to work but give them nothing at all to do. Eventually, sheer boredom or exasperation drives the workers to quit.

Many accidents and injuries are associated with tractors and other farm machinery and vehicles. Despite laws requiring that all tractors must have drivers, a farmworker reports

The dangerous equipment involved in agricultural work presents serious hazards for workers.

¹⁸ Rosenberg, et al., Who Works on California Farms?

¹⁹ Occupational Safety and Health Administration, <http://www.osha.gov/SLTC/agriculturaloperations/index.html>.

²⁰ If a condition is not completely debilitating (i.e., requiring complete time off), workers are sometimes put on light duty—work with restrictions such as not lifting items beyond a certain weight or not bending down for more than two hours at a stretch.



that “there are many injuries when tractors run people over, which is especially a problem when people work alongside a tractor with no driver.” Cuts and lacerations are also common, as many tasks involve using sharp knives for harvesting and farmworkers are often pressured to work quickly. In addition, farmworkers suffer from repetitive stress injuries associated with their work in fields and packing houses, particularly when no ergonomic support is provided.

Farmworkers who sustain work-related injuries and illnesses are entitled to medical treatment and are eligible for Workers Compensation regardless of their documentation status. Unfortunately, there are many problems with the system, and it is often difficult for workers to receive medical attention because access is at the discretion of foremen. According to the director of CRLA, “the Workers Comp system is dysfunctionally broken.” Foremen are purportedly reluctant to send workers to doctors, preferring to treat problems in the fields when they do not consider them severe. A farmworker who has picked lettuce for many years described her ordeal.

Access to medical attention in the fields is at the discretion of foremen who sometimes choose to ignore complaints or give only superficial first aid.

After three weeks of the new season, I started feeling back pain. My legs were really swollen and then my waist got very swollen. It felt like something was broken. I started wondering what was going on, because after so many years of doing this, I had never experienced these aches before. I took pain pills that a friend recommended, but nothing would work. After two weeks of taking pills, I couldn’t take it anymore. Finally, I asked my supervisor for a slip so I could see the doctor. . . . I told him that my legs were hurting really badly. He said the only way I could get a slip was if I slipped and fell. I told him that was difficult because I hadn’t fallen and yet felt like I was losing feeling in my legs and was getting paralyzed. Well, that was that. I didn’t get the doctor’s slip, and my supervisor didn’t help. The only thing I could do was hold myself up with the help of my friend, and when I came home, I would lie down and not move for the rest of the night. I went to the *mayordomo* again the next week and asked him to give me the doctor’s slip. He said “No. What’s wrong with you?” I reminded him how I had told him the previous week that I was feeling badly, that something was happening to me. That was when he finally gave me the slip.

Another farmworker, who is now a foreman, recounted the following experience.

Once, when I was driving a bus, I heard someone crying. When we got back from the fields, the woman that was crying fainted after she got off the bus. I said, “What happened to her?” They told me she got hit hard by a machine and was crying from the pain the whole way. I asked what the *mayordomo* said. They said she told him, but he said it was a fake pain and wasn’t going to give her permission to leave. I told the *mayordomo* that she needed to see a doctor, but he said it was just a small *golpe*/hit.

He went on to describe what he now does as a foreman when he considers injuries to be minor.

There are lots of cuts. It’s a matter of the work that you’re going to get cut, because you’re working with a knife. But it’s *pasajero*/temporary. I put a disinfectant spray and a band-aid or gauze and tape on the cut and that’s it. But *if the cut is deeper than an inch* [italics added], I have to take the person to the clinic.



According to a union representative, most farmworkers are not aware that they can designate their own Workers Compensation doctors when signing contracts with employers and farm labor contractors. Without such a designation, they can be required to see company doctors, who are purportedly more likely to reject Workers Compensation claims. That changed on June 1, 2003, however, when regulations requiring employers to notify workers of this right went into effect.

Compensation restrictions also discourage farmworkers from reporting problems or seeking Workers Compensation benefits. Under the current system, they receive no pay for the first three days they cannot work and are paid nothing if the claim is not approved beyond that three-day period. They therefore run the risk of losing three days or more of income if a claim is denied.

Many farmworkers report that company doctors do not properly diagnose their problems and do not give them permission to take time off when they feel it is necessary. An ex-farmworker, for example, described his experience with the system.

The main problem farmworkers have is that the company doctors don't treat them well. They don't diagnose problems correctly and don't give good medicine. When I was a farmworker, I hurt my shoulder and they sent me to the company doctor. He didn't give me permission to rest, so I had to go back to work the next day, even though I was injured.

Several informants suggested that physicians from Doctors on Duty, a major provider of care for farmworkers, are essentially "company doctors," in that they advocate for growers. They believe that Doctors on Duty physicians often diagnose work-related injuries and illnesses as old or unrelated conditions and are less likely to approve Workers Compensation claims than other physicians. CRLA's director expressed similar concerns. "I suspect that the company doctors are in cahoots with the growers. I think there's probably pressure [from] growers for the doctors not to approve too many Workers Comp claims."

According to another provider at CRLA, the situation is exacerbated by some farmworkers.

[They] wait several days or weeks before reporting a problem, hoping it will go away by itself. By the time they do report a problem, the *mayordomos* will often claim it's not work-related, which makes it even more difficult for farmworkers to get Workers Comp.

Despite these problems, there are a number of growers who provide their workers with good working conditions and good medical attention when they are hurt. One farmworker described an example of a positive experience.

One time I strained my back. The company brought me to some doctors here in Gonzales. The insurance company paid for everything. . . . I didn't work for two weeks because of my injury, and they paid me for those two weeks.

Restrictions on benefits and lack of paid sick time discourage farmworkers from seeking treatment for injuries and illnesses.



Pesticide Exposure

Monterey County had the state's third highest number of reported pesticide poisonings in 1997 and 2000.

Pesticide exposure is an occupational hazard meriting special attention. Data from California's Department of Pesticide Regulation (DPR) indicate that Monterey County registered the third highest number of reported pesticide poisoning cases in the state between 1997 and 2000. The majority of claims are associated with lettuce, broccoli, and grapes. *Fields of Poison*, a report issued by Californians for Pesticide Reform in 2002, reports that drift and residue accounted for 51 and 25 percent of all poisoning cases, respectively, between 1998 and 2000. Most of the remaining cases were direct sprays or spills and occurred most often to those applying the pesticides.

A number of farmworker informants believe they are being negatively affected by pesticides and reported a range of symptoms.

Work is good for you, because that's how you eat. But in the long term, it affects your health, because of all the chemicals added to the crops.

Work doesn't affect my health. What affects you are the chemicals. They put strong chemicals on the vegetables. They add the chemicals so that you will harvest more. . . . I know that the chemicals affect you because you get rashes on your hands.

I get rashes on my hands. They say that they use a little bit of chlorine on the asparagus. They put chlorine in the water so that the asparagus is washed well before it's packed. I stopped working in July [the interview was conducted in October of the same year] and I still have the rash.

According to the director of CRLA, chlorine exposures in packing houses are becoming more common.

The lettuce growers are increasingly selling "lettuce in a bag," which is pre-washed. It's clearly important for that lettuce to be very clean, which entails washing it in a Clorox solution. That has become increasingly problematic over the last three years, and workers in the packing sheds have complained of problems associated with exposure to the chlorine and fumes, including eye and skin irritation, headaches, and nausea. . . . When farmworkers seek medical attention from company doctors, they're often told that these are pre-existing conditions or that they have conditions such as Alzheimer's disease. This is a problem that OSHA doesn't take seriously.

However, a technical specialist at the Grower-Shipper Association claimed that problems associated with exposure to chlorine are unlikely.

Chlorine is used to sanitize equipment only. A very weak solution is used—less than 10 percent, which is the same as what you would use at home. The chlorine is not used directly on the lettuce; only water is used to clean the lettuce. The chlorine is only used on the machinery in the packing sheds and in the fields to make sure the equipment is clean.

Many families, both farmworkers and non-farmworkers, live in close proximity to fields and experience high levels of exposure to pesticides even though they do not work with sprayed plants. The Center for Health Analysis of Mothers and Children of Salinas (CHAMACOS) study is currently researching the effects of pesticide exposure on Salinas



Valley children from birth through age three.²¹ Though this study is still under way, other reports are disquieting. According to *Fields of Poison*,

In a recent study in the apple growing Yakima Valley of Washington State, researchers . . . found that 56 percent of children whose parents worked in the orchards received organophosphate pesticide doses exceeding U.S. EPA's chronic reference dose for azinphos-methyl—a highly toxic nerve poison."²²

DPR data indicate that the number of reported pesticide incidents in Monterey County has decreased in recent years, which the county agricultural commissioner attributes to a number of factors.

Good enforcement programs, good outreach, stronger laws, changes in the types of pesticides used, increased compliance with the laws, and fewer mistakes in the application of pesticides. Applications are increasingly being done by licensed professionals who are trained and are liable for their mistakes, which gives them an incentive to do their work well. Visibility in the Salinas Valley area also improves compliance—this area is very flat with low crops, and visibility is high. It's hard to make mistakes that go unnoticed because of that, unlike orchards or vineyards, where it's easy for mistakes to go undetected.

However, observers note numerous discrepancies between official reports and the actual number of pesticide poisonings. According to *Roots of Change*, many incidents are not reported by farmworkers because of “lack of medical insurance, fear of retaliation by employers, or insufficient training of medical personnel to recognize symptoms.”²³

Critics also fault the agricultural commissioner for not holding growers accountable for pesticide-related incidents, such as a case of pesticide drift that sickened twenty-three workers in the Salinas Valley for which no sanctions were levied against the grower or pesticide applicator. The commissioner explained that he could not prosecute because no pesticide residue was found where the crew had been working. He expressed a need for stricter laws.

The agricultural commission can only enforce existing laws; it does not create laws regulating pesticide use. . . . Pesticide drift is a legitimate concern. There are no laws regulating the distance farmworkers have to be from an application if the application is in another grower's fields. It's the responsibility of the pesticide applicator to decide whether or not to spray if, for example, there are farmworkers in the adjacent fields, which may be downwind from where he is going to spray.

Pesticide exposures occur when economic considerations override health and safety concerns.

A farmworker informant who flies a crop-dusting plane demonstrated why such decisions cannot safely be left up to the applicator.

I often see farmworkers in the fields next to the one I'm about to spray. I know that the pesticides I'm going to spray are going to reach them, but I go ahead and spray anyway. I have a job to do.

²¹ The study is being conducted by the Epidemiology Department at UC Berkeley.

²² Reeves, et al., *Fields of Poison*.

²³ Funders Agricultural Work Group, *Roots of Change*.



The need for stronger statutory control was corroborated by the director of CRLA.

In general, there is compliance with pesticide regulations, but the regulations are too weak. We see many truck drivers and irrigation workers complaining of pesticide exposure. Protective gear is only offered to those actually spraying, not to anyone else working in sprayed fields. Although farmworkers are aware of the dangers of direct exposure to pesticides, there is a need for basic education on prevention around issues such as clothes and contact with children.

Growers are required to provide farmworkers with pesticide safety training, but there are many issues the trainings do not cover and farmworkers are not always able or willing to take the extra steps prescribed to protect family members. For example, a CRLA outreach worker cited the case of a farmworker “who threw his work jacket, which was covered with pesticide residues, in the back of the car, where his small child was seen chewing on it.” CRLA conducts pesticide safety trainings that address ways to reduce pesticide exposures outside the workplace by teaching farmworkers precautions such as changing clothes and showering before hugging their children, not sitting on furniture or getting into bed with work clothes on, and washing clothes worn in the field separately. However, as the director of CRLA points out, the issue is complicated.

For example, when women leave work, they time picking up their children at child care down to the minute. They don’t have time to shower or even change clothes before picking up their children. And, even though they’re aware of the problems, they’re not willing to not hug their children when picking them up. Similarly, even though many people know they should wash their work clothes separately, they’re unwilling or unable to pay more to do additional loads of laundry at the laundromat.

In terms of health priorities, the agricultural commissioner feels the relative importance of pesticides may be exaggerated.

The risks associated with pesticides are far less than what most people think. Pesticide exposure is a much smaller health problem for farmworkers than other more pressing issues they face, such as overcrowded housing, poor diet, or substance abuse and alcoholism. In that sense, a focus on reducing pesticide exposure will probably not provide the “biggest bang for the buck” with respect to improving farmworker health.

Health Care Delivery System

The Salinas Valley offers a wide range of facilities for the delivery of primary health care via nonprofit, public (county), and private for-profit clinics, three hospitals, and several visiting nurse and mobile clinic programs. These facilities are heavily concentrated in the city of Salinas, making it difficult for farmworkers in the southern reaches of the county to access care.

Farmworkers also rely on a network of traditional providers, including *sobadores* (masseurs), *curanderos* (healers), *comadronas* or *parteras* (midwives), and *botánicas* (pharmacies).

It is important to educate farmworkers about how to avoid exposing their families to pesticide residues from their clothing.

Inventory of Health and Social Service Providers

Nonprofit and Public Health Care Providers

Clinica de Salud del Valle de Salinas

The major provider of primary health care for farmworkers in the study region is Clínica de Salud del Valle de Salinas (Clínica de Salud), established in 1980. This Joint Commission on Accreditation of Health Care Organizations (JCAHO)-accredited nonprofit system operates medical clinics in Salinas (two), Castroville, Chualar, Soledad, Greenfield, and King City. According to California Office of Statewide Health Planning and Development (OSHPD) data, Clínica de Salud served 28,500 patients during calendar year 2000, nearly three-quarters (72 percent) of whom were farmworkers or their dependents.

Clínica de Salud provides a broad range of services, including family practice, women's health, preventive medicine, internal medicine, pediatrics, laboratory services, dental care (see separate section on dental care later in this report), and health outreach and education. They hope to add vision care in the future. In addition, a grant proposal to fund mobile clinic services is pending.

With the exception of some counseling and case management services for pregnant women (through the county's Comprehensive Perinatal Services Program (CPSP)), Clínica de Salud provides no mental health services.

The clinics rely on nineteen physicians, most of whom are family practitioners. The medical staff also includes a pediatrician, an internal medicine specialist, and an obstetrician/gynecologist, as well as a physician assistant, four registered nurses, one licensed vocational nurse, and thirty-six medical assistants. In addition to primary care, medical assistants provide health education, outreach, and diabetes and blood pressure screenings at health fairs, community events, and door to door throughout the Salinas Valley.

Since the majority of Clínica de Salud's patients are farmworkers and their families, most medical providers speak Spanish. Medical assistants provide assistance with translations when necessary. Staff informants noted that it is difficult to hire and retain good bilingual physicians, dentists, and nurses given the relatively low salaries and high living costs in the area. The organization's chief executive officer has been involved in recent legislative efforts to address this problem by bringing more health care providers from Mexico.

OSHPD data indicate that the incomes of 77 percent of Clínica de Salud's patients fall below 100 percent of the poverty line; the rest fall below 200 percent. Under the clinics' sliding fee scale, uninsured patients pay between 50 and 100 percent of the \$65 cost of a visit. There is, however, a \$25 deductible that all patients are expected to pay. Clínica de

Clínica de Salud operates primary care clinics throughout the Salinas Valley. About three-quarters of the clinics' patients are farmworkers and their families.



Salud also offers long-term payment plans. The chief financial officer described the system’s compensation structure.

About 60 percent of Clínica de Salud’s patients are Medi-Cal, 5 percent are Medicare, a few are private pay, and the rest are uninsured. We charge uninsured patients on a sliding fee scale, but there are many that we treat for free. We treat everyone here, regardless of insurance status.

The system’s willingness to accept patients regardless of their ability to pay has had negative repercussions on the financial health of the organization.

Monterey County Health Department

The county’s Alisal Health Center is set up mainly to serve Medi-Cal patients, but no one is turned away for lack of insurance or ability to pay.

Of Monterey County Health Department’s three primary care clinics, only one, Alisal Health Center (Alisal) on Salinas’ predominantly Latino/farmworker east side, is located in the Salinas Valley. There are no public clinics offering primary care in the southern part of the county.

Alisal employs three physicians, one physician assistant, two family nurse practitioners, one pediatric nurse practitioner, two registered nurses, seven medical assistants, and six receptionists. All of the clinic’s providers speak enough Spanish to see patients without assistance from a translator. Services include prenatal care, family planning, pediatrics, women’s health care, well-child exams, immunizations, and primary general health care for patients of all ages.

According to a staff member, Alisal’s patients are mostly farmworkers and their families.

Virtually all of our patients are low-income and Spanish speaking. The vast majority—more than 75 percent—are from farmworker families. Most patients are mothers and kids with Medi-Cal. That is our target population by default, since single men don’t get Medi-Cal. Most patients are pregnant, and for many, this is the first time they are able to see a doctor because they now qualify for emergency Medi-Cal. Many of our patients have never seen a doctor before in their lives. Some, mostly from Michoacan, have been here [in the U.S.] for a long time and can maneuver the system to access services. More recent arrivals have a harder time.

Though Alisal is geared to serve Medi-Cal patients, no one is turned away for lack of insurance or ability to pay. Sliding fee scales discount up to 100 percent of the costs, and county Department of Social Services eligibility workers stationed at the clinic help uninsured patients obtain Medi-Cal and other forms of coverage. Clinic staff members report that they are often, though not always, able to find programs to cover the cost of treating patients, as the clinic manager explained.

We’re almost always able to qualify someone for some program. If someone comes to us who does not have Medi-Cal, we use presumptive Medi-Cal eligibility and sign them up on the spot based on the income data they provide us with that day. They can then get care through the end of the month but afterwards must apply for Medi-Cal through normal channels. However, the working poor



are falling through the cracks. There is a big discrepancy between poverty levels and the actual cost of living. We need to base [Medi-Cal] eligibility on the cost of living, which is very high around here. This is having a huge impact on public health.

Treating the uninsured presents serious challenges to Alisal's financial and economic viability, as the manager explained.

The clinic is an FQHC [federally qualified health center] provider—we only see people with Medi-Cal or no insurance. FQHC funding is our lifeblood. However, FQHC will cut our funding if we don't see enough Medi-Cal patients. We need the Medi-Cal patients to cover the costs of seeing the uninsured. As a result, we don't turn the uninsured away, but we don't do any outreach to get them to come to the clinic. That's a big problem in terms of providing services to that population. There's a health insurance crisis around the corner. Medi-Cal eligibility requirements are getting stricter, and there are fewer and fewer private providers that are willing to take Medi-Cal patients. Clínica de Salud has the same problem—the percent of Medi-Cal patients they see is the same as us.

According to a physician at the clinic, funding guidelines are also a barrier to providing needed services for low-income patients.

There's a need for comprehensive health care. People don't fit into specific parameters; they have lots of issues. But funding guidelines can be very specific. For example, there may be funding for certain areas of need only, such as reproductive health, but not for other problems like high blood pressure or thyroid problems. We need to find creative ways to get around that, so sometimes we give people condoms so we can bill the visit to a reproductive health program. But many patients still fall through the cracks because of these very specific guidelines. For example, we didn't have funding for breast cancer and we saw a patient with very aggressive breast cancer. She had to wait six months to receive treatment.

Monterey County also operates Natividad Medical Center (Natividad), which consists of a 163-bed acute care hospital and thirteen outpatient clinics in Salinas.

Natividad's hospital has been affiliated with the University of California San Francisco School of Medicine since 1974 and is the only academic medical center on the central coast. It is also host to a nationally recognized family practice training program providing postgraduate training for physicians specializing in family medicine. Thanks to this affiliation, Natividad's hospital is a state-of-the-art facility accredited by JCAHO. Many of the approximately 1,000 staff members are Latino and Spanish-speaking. Natividad offers a wide range of basic and specialized medical services and also runs the county's Medically Indigent Adult program.

Natividad's outpatient clinics saw more than 155,000 patient visits during 2002, a figure that has been climbing steadily in recent years. The clinics offer a broad range of services, including family medicine, pediatrics (including general pediatrics, adolescent medicine, and a child advocacy center), internal medicine (including general internal medicine, pain management, and infectious disease treatment), mental health care, women's services,

Monterey County's Natividad Medical Center is a state-of-the-art facility associated with the UC San Francisco School of Medicine.



surgical services, diagnostic and therapeutic services (including physical therapy, speech therapy, audiology, occupational therapy, diagnostic imaging, mammography, and ultrasounds), and specialty care (including adult and pediatric cardiology, gastroenterology, neurology, nutritional services/education, occupational medicine/Workers Compensation, ophthalmology, adult and pediatric orthopedics, plastic surgery, podiatry, pulmonary and nephrology care, sports medicine, urology, and vascular surgery).

Natividad Medical Center is the valley's primary provider for uninsured individuals, a financial burden that may force Natividad to close several of its smaller clinics.

Natividad is the main health care provider for Monterey County's uninsured population, which includes many farmworkers. Approximately half of the center's patients receive Medi-Cal or are uninsured, which has contributed to the center's current \$12 million deficit. As a result of that deficit, Natividad is considering closing several of its clinics, which would have dire consequences for farmworkers and other low-income patients throughout the Salinas Valley.

The Monterey County Health Department operates the King City Health Center, a public health clinic serving south Monterey County. While the center provides no primary care services, it offers access to Planned Parenthood services once a week and immunization and tuberculosis clinics twice a month. The center serves between fifty and one hundred patients a month, about 90 percent of whom are farmworkers. It also coordinates the county's public health nursing program for southern Monterey County, which serves an additional eighty families, virtually all of whom are farmworkers.

Mee Memorial Hospital

Mee Memorial Hospital (Mee) in King City is a nonprofit, 501(c)3 independent hospital. Approximately 90 percent of the hospital's 300 staff members are Hispanic. Specialized services include nephrology, orthopedics, ophthalmology, dialysis, and gynecological surgery. Uninsured patients are referred to Natividad, as are patients who require specialized services that Mee does not provide, such as cardiology. The hospital also recently began operating a mobile clinic with two examination stations to deliver care to isolated communities such as San Ardo and San Lucas.

Mee operates two outpatient clinics in southern Monterey County, one in King City and one in Greenfield, that together receive about 6,000 primary care visits per month. Each has approximately twenty medical providers, although some are specialists who come in only periodically to provide vision, urology, obstetric, pediatric, orthopedic, podiatric, and gastroenterology services.

Approximately 70 percent of the King City clinic's patients are farmworkers and their families; however, only 30 percent of its providers speak Spanish. Translations are provided by bilingual staff and family members. This clinic also employs a bilingual nurse practitioner who travels to outlying communities such as San Lucas and San Ardo.



An estimated 90 percent of patients at the Greenfield clinic are farmworkers, approximately 25 percent of whom have no insurance. Fortunately, the clinic offers long-term payment plans and a 40 percent discount for cash payments. The clinic is also unique in that about 50 percent of the farmworkers seen there are indigenous-language speakers. While virtually all of the clinic's providers speak Spanish, none speak indigenous languages, nor do they have any professional translators. Consequently, they must rely on family members to translate.

Salinas Valley Memorial Health Care System

Salinas Valley Memorial Hospital in the city of Salinas, a 195-bed acute care, JCAHO-accredited medical center, is the largest hospital in the Salinas Valley. The Salinas Valley Memorial Health Care System includes fourteen urgent care clinics, two outpatient surgery centers, imaging centers, home care services, adult day care for patients with dementia, hospice care, and assisted living facilities.

One of the urgent care centers, Harden Medical Care Center in Salinas, specializes in Workers Compensation cases. Farmworkers and their families comprise about 25 percent of the center's patients, almost all of whom have some form of insurance. Harden has thirty employees, including five medical providers. Two of those providers are bilingual, and nearly all of the support staff speak Spanish. The clinic has no professional translators.

Private For-Profit Clinics

Private, for-profit clinics serving farmworkers are relatively numerous in the Salinas Valley. Some function like nonprofits, offering sliding fee scales and assistance with applications for Medi-Cal and other insurance programs. Others refer people without insurance to providers such as Clínica de Salud and Natividad.

Clínica Universal

Clínica Universal (Universal), located on Salinas' east side, is owned and operated by a physician who was once a farmworker. He has lived in Salinas since 1979 and helped found Clínica de Salud. He set up Universal to serve the many uninsured people who came to his main clinic. Nearly all of Universal's patients are farmworkers and their family members. A flat fee of \$35 per visit must be paid in cash, as the physician/owner explained.

The clinic can afford to do that because the cost of a clinic visit is about \$25 for us. We charge cash and don't have to bill out to get reimbursed, which increases the cost by 30 percent. My work is pro bono and the building has already been paid for, which lowers our costs significantly. The average copay in Salinas for people with health insurance is \$40, so even people with insurance prefer to come here because it's \$5 cheaper for them.

Clínica Universal's charges must be paid in cash. This system frees the clinic from the burden and expense of processing insurance claims, allowing them to charge just \$35, less than many insurance plan copays.



However, the clinic cannot subsidize diagnostic tests or medications, a serious impediment to comprehensive care.

There is only one lab and one radiology group in town. Both are monopolies with very high prices. Lab tests often cost hundreds of dollars. If a patient requires x-rays or hospitalization, that can lead to bankruptcy. If a patient needs essential tests, we charge them payments—farmworkers are very good about paying their bills. But we need to be very selective about which tests to order. We only order expensive tests if they are absolutely necessary, but prefer more hands-on medicine, with careful follow-up.

Santa Lucia Medical Group

Santa Lucia Medical Group is a private family practice clinic in Salinas. In operation since 1987, the clinic has thirty staff members, including four physicians and a physician assistant. All speak Spanish. Virtually all of this clinic's patients, about 65 percent of whom are farmworkers, have some form of insurance coverage. Clinic staff members help enroll eligible patients in appropriate programs, and those who are not eligible are referred to the county's program for medically indigent adults at Natividad. The practice also offers diabetes education.

Gonzales Medical Group

Gonzales Medical Group provides primary care outpatient services and refers patients to Natividad for specialized services. Almost all of the group's patients are Latino and more than 50 percent are farmworkers. Most have Medi-Cal coverage, but no one is turned away for lack of insurance. The clinic endeavors to enroll patients in appropriate insurance programs, and uninsured patients are entitled to a reduced rate of \$20 per visit. The clinic also gives sample medications to patients who cannot afford prescriptions. In addition, a staff member works nearly full time arranging for free medications from various pharmaceutical companies' drug assistance programs. Fee-for-service and Medi-Cal payments are supplemented by funding from the federal Rural Health Care program.

Alta Medical Center

Alta Medical Center in Gonzales is a private, walk-in urgent care clinic in place since 1992. It is owned and operated by a surgeon from the Philippines who is also the only physician on staff. The majority of the clinic's patients are farmworkers. Approximately 50 percent of patients are uninsured and pay out of pocket. The first visit costs \$65; subsequent visits cost between \$35 and \$45. Payment plans and sample medications are available for those who cannot pay up front. The clinic also helps eligible patients enroll in Medi-Cal and other programs and refers uninsured patients who cannot afford to pay out of pocket to Natividad.

Some of the valley's private providers operate more like nonprofit or public ones, endeavoring to provide patients with payment plans, sample medications, and assistance enrolling in public health insurance.



Doctors on Duty

Doctors on Duty consists of fourteen clinics owned by Salinas Valley Memorial Health Care System and Cypress Health Care Partners. These clinics offer a full range of services but specialize in injuries related to agricultural work. Salinas has three Doctors on Duty clinics, one of which provides urgent care. There is also a clinic and urgent care facility in Greenfield. Workers Compensation covers about 75 percent of urgent care treatment. Approximately 10 percent of Doctors on Duty patients have Medi-Cal; most pay out of pocket or through private payers. The clinics do not provide a sliding fee scale or payment options, and indigent patients are referred to Natividad.

Doctors on Duty is currently the principal health care provider used by growers for treating injured farmworkers and verifying Workers Compensation claims. However, a representative of Doctors on Duty predicts this will change when new regulations requiring employers to inform farmworkers of their right to select a Workers Compensation health care provider take effect in June, 2003. He believes that more farmworkers will seek chiropractors because the hands-on style of chiropractic care is similar to that of Mexican physicians.

Traditional Healers

The type of traditional healer most frequently mentioned by farmworkers is the *sobador*/masseur. Farmworkers consult *sobadores* for a variety of complaints, particularly joint and muscle pain, fertility problems, and ethnospecific conditions such as *empacho*/upset stomach, *mollera caída*/sunken fontanel, and *matriz caída*/prolapsed uterus. *Sobadores* generally charge much less than western health care providers, typically between \$10 and \$15 per treatment.

Smaller but still substantial numbers of farmworkers see *curanderos*/traditional healers, who employ herbal treatments and conduct *limpias*/cleanings to improve their clients' health and well-being and to ward off illness and misfortune. However, *curanderos* are controversial in the Latino community; many farmworkers shun them, believing them to be associated with witchcraft.

In addition, there are a number of traditional "drugstores" known as *botánicas* in Salinas. These establishments sell a variety of over-the-counter products, including herbs, charms, and other items that are meant to promote improved health and well-being. Most *botánica* owners offer services as *curanderos* as well.

Farmworkers choose to see traditional healers for a number of reasons. Many believe they are more effective for ethnospecific conditions. They also charge less than western providers and generally have more accessible hours. Many also turn to traditional healers when western medicine fails them, as a former farmworker now working as a nurses aid explained.

Traditional healers continue to thrive in the farmworker community. They provide care that is familiar to Mexican immigrants and are often consulted regarding ethnospecific illnesses and conditions.



I've used a *sobadora*. A friend of mine recommended her after another nurse and I had to move a very heavy patient from one bed to another. Afterwards, I felt pain. I went to the *sobadora* because the doctor couldn't find anything wrong with me, even though I kept telling him I had a lot of pain. The doctor even sent me to have some studies done, but nothing turned up. I was charged \$1,500 to find out nothing was wrong. So, that's when I went to the *sobadora* and she told me my uterus had fallen. One time, at a clinic in Salinas, I commented on how the doctors here don't see these types of things. I told him what the *sobadora* had said. He said that in the U.S. they don't believe in things like the uterus falling, but we Mexicans know that can happen and we need to be careful when we lift things.

Dental disease is all too common among farmworkers and their families, including very young children. Some 20 percent of farmworker children under the age of five have serious dental problems.

Reproductive Health Clinics

Planned Parenthood

Planned Parenthood operates clinics in Salinas, Greenfield, and King City. Services include annual exams; birth control; breast, cervical, and testicular cancer screening; emergency contraception; HIV testing and counseling; pregnancy testing and counseling; and testing and treatment for sexually transmitted diseases. Additional services offered at the Salinas site are non-surgical abortions, prenatal care, and sterilization for men and women. According to OSHPD, Planned Parenthood served more than 6,000 patients in the Salinas Valley during 2000, 14 percent of whom were farmworkers or their dependents. The bulk of Planned Parenthood's patient encounters are for family planning services; HIV testing and counseling services accounted for 8 percent of all patient encounters in 2000.

Confidence Pregnancy Center

Confidence Pregnancy Center is a nonprofit organization that has served the Salinas community since 1984. It currently provides free services to more than 500 women annually, about 25 percent of whom are farmworkers or members of farmworker families. The program provides ultrasounds and pregnancy tests to verify that women are pregnant so that they can then qualify for Medi-Cal. The center also offers counseling, referrals for prenatal care and other medical and social services and for maternity clothes, infant formula, diapers, clothing, and furniture for children up to age four. In addition, the center conducts pregnancy prevention outreach for middle school and high school students throughout the Salinas Valley.

Dental Providers

The majority of farmworkers suffer from poor dental health. Screenings of children under age five indicate that two in three suffer from some degree of dental disease, and one in five experiences severe problems.²⁴ The principal dental providers serving farmworkers in the Salinas Valley are Clínica de Salud, Appolonia Foundation, and Sanger, Stewart,

²⁴ Appolonia Foundation Children's Oral Health Program data.



Chiang, Morris and Murillo, a private pediatric practice in Salinas. A limited number of other private dentists and practices also serve farmworkers with Medi-Cal.

Clinica de Salud

Clinica de Salud provides dental care for adults and children at its Salinas, Soledad, Castroville, Greenfield, and King City clinics, providing one-stop settings for medical and dental care. Approximately 2,000 patients seek dental care each month. Services include fillings, extractions, root canals, oral surgery, and dentures. Patients requiring sedation or with severe conditions are referred to other dental practices in Salinas.

Services are provided by a staff of seven dentists (six full-time and one half-time), fourteen dental assistants, and six administrative staff. According to the program's director, all dentists speak "dental Spanish." All support staff members are bilingual and provide translation when necessary. Efforts to recruit Latino and Spanish-speaking dentists have met with little success, due to the limited number of Latino dental graduates, the rural location of most of the clinics, and competition from for-profit practices.

Approximately 25 percent of Clínica de Salud's patients are enrolled in the state's Healthy Families program. Another 60 to 65 percent have some form of Medi-Cal coverage, and the rest pay cash. The clinics offer uninsured patients a sliding fee scale, with discounts of 25 to 75 percent, as well as long-term payment plans. However, given the high cost of dental care, the clinics cannot meet all of the needs of the area's many uninsured patients. As the director explained, "some people invariably fall through the cracks."

Appolonia Foundation for Children's Dental Health

Appolonia Foundation for Children's Dental Health is a nonprofit organization that provides dental services to children. Smiles on Wheels is Appolonia's full-service portable dental clinic, which has been in operation since 1998. It serves low-income children up to age nineteen in medically underserved areas of Monterey County, including Soledad, Gonzales, Greenfield, King City, San Lucas, San Ardo, and Bradley. The center's bilingual staff sees nearly 1,000 patients annually, more than 85 percent of whom are from farmworker families. The clinic remains in each location for several months in order to serve all of the region's communities during the year.

Appolonia's Children's Oral Health Program (COHP) began operations in December, 2000. Funding is from the Monterey County Children and Families Commission, which has limited the program's services to expectant mothers and children from birth to age five. With seven full-time and two part-time staff members, all of whom speak Spanish, the program can effectively serve many farmworker families. COHP covers treatment, but prevention is its primary goal. According to the program's director, "investments in prevention will have greater long-term benefits than short-term investments in treatment."

Appolonia's Smiles on Wheels is a portable dental clinic that is periodically moved from site to site throughout the valley to provide low-income children with dental care.



Appolonia's Toothmobile van brings dentists into the community to provide basic dental care for needy children.

Although we believe in treatment, dental disease is preventable, and we felt that if we could put these resources into prevention, instead of damage control, we could make a major difference. . . . Our philosophy is that our work has to be a two-pronged strategy—as equal on the prevention side as on treatment. It's a matter of “working smarter, not harder,” so we can fit in the time we need for prevention. Others have given up on prevention, but we're not giving up.

COHP uses a case management model, working in close collaboration with Head Start, as the director explained.

We use a “reach and repeat” strategy. First, we train the professionals—the teachers, support staff, and home day care providers—to recognize dental problems and teach preventive practices. Then we screen the kids, where we identify problems and start case management. After that, we go back to the families . . . to teach parents about how to prevent dental disease. After children are screened, Class One children, who have no visible dental problems, are contacted via mail and are recommended to visit a dental provider. An incentive of free dental products is offered to these families. Classes Two, Three, and Four children are contacted via phone and are put into case management, where insurance, dental homes [a permanently assigned dentist], and other assistance are provided. It's difficult to find dental homes for undocumented kids, since they're not eligible for Healthy Families. That's always a tough case for us.

COHP also operates the Toothmobile, a van from which dentists provide basic dental care, including screenings, cleanings, and sealants.²⁵ The Toothmobile is currently staffed one day a week and recruitment for a second day is under way. The program's goal is to offer a dentist four days a week. The director notes that the van is helpful but is not a replacement for a permanent dental provider.

Mobile clinics are great, but if they're not there when you come back six months later, then you've left that family with a gap. We cherish what we can do in the mobile facilities, but it's really a tool that we use to convince families to find a provider that will take Medi-Cal or California Kids.

COHP staff members also distribute English and Spanish language videos about oral health to parents of newborns as they leave the hospital and train medical providers to identify dental disease while conducting routine checkups. The program director described the disconnect that often occurs between medical and dental health.

The mouth is part of health but is often treated as an out-of-body experience. Physicians say “open your mouth” and they look at your tonsils. They go right past your teeth! That's why another huge component of our work is to do professional training.

Sanger, Stewart, Chiang, Morris and Murillo

Sanger, Stewart, Chiang, Morris and Murillo is a pediatric dental practice with four clinics in Salinas. Two of the clinics see patients with private insurance only. The other two—one for children age zero to six and one for children ages seven to eighteen—accept patients

²⁵ Whereas the Mobile Dental Center is a portable unit that must be relocated on a flatbed truck, the Toothmobile is a van that can be driven from site to site.



with Medi-Cal and other forms of public insurance. This is the only pediatric dental practice in the Salinas Valley that accepts Medi-Cal. As a consequence, it can take as long as three months to get an appointment. It is also the only pediatric Medi-Cal-accepting practice that treats severe dental disease.

The majority of patients at Sanger are Spanish-speaking, and the clinic staff estimates that most are from farmworker families. Though only one of the five dentists in the practice speaks Spanish, nearly all the support staff, including dental assistants, are bilingual.

Because the practice treats children, nearly all of its patients have some form of health coverage. However, public programs do not always cover all of the costs of care, such as sedation, which is required for severe cases and for very active children. The clinics are currently too busy for staff to help enroll patients in public programs, so they refer patients to Natividad's Managed Care Center for assistance. They also rely on donations from Children's Miracle Network when insurance does not cover all of the cost of treatments.

In addition to treatment, the practice provides outreach and screenings at schools and participates in health fairs throughout Monterey County.

Mental Health Providers

Monterey County Department of Behavioral Health

The majority of mental health services provided by Monterey County's Behavioral Health division are for people with acute mental illnesses; few services are available for less severe, situational mental health problems. The county serves adults covered by Medi-Cal and children who qualify for Healthy Families or Medi-Cal. In addition, there are very limited emergency services for the uninsured. Adult services are provided almost entirely in Salinas. The only extension is to King City once a week.

Children's mental health services are offered at the Salinas and King City sites, but most services are home- and school-based. Referrals typically come from schools, probation officers, and the Department of Social Services. While approximately one-third of the children seen come from farmworker families, the program has just four Spanish-speaking providers.

Natividad Medical Center

Monterey County's Natividad Medical Center includes a mental health outpatient clinic and a twenty-two-bed inpatient facility that together employ a staff of thirty-five. The county also maintains a twenty-four-hour crisis team at its hospital emergency room. Outpatient care is available only to people who have Medi-Cal or private insurance.

Mental health services in the Salinas Valley are extremely limited in their capacity and are heavily concentrated in the city of Salinas.



Catholic Charities

Catholic Charities relies on interns under the supervision of a licensed therapist to provide individual, couple's, and children's counseling on a sliding fee scale. Catholic Charities interns also work at schools, where they provide family counseling for parents and children. Three of the program's twenty interns are bilingual, which severely limits the number of Spanish-speaking clients the program can serve.

Other Mental Health Providers

A number of other nonprofit organizations provide counseling, but only within the context of each agency's larger mandate—domestic violence, for example, or substance abuse.

Churches are an important source of counseling and support for the farmworker community, which turns to religious leaders for assistance with many problems, particularly conflicts with spouses and children. Local priests and pastors play an important role in their capacity as lay therapists. Many churches also coordinate various retreats and gatherings, such as bible study groups, that function as de facto mental health support groups. Also important are the social activities organized around churches, which provide opportunities for recreation and socializing that are crucial in combating isolation and associated depression.

Health Education and Outreach

Residents of the valley benefit from several visiting nurse programs, one that provides care for homebound individuals and another that provides education, information, and referrals.

Health education is an essential component of all public health campaigns. Most of the public and nonprofit agencies and organizations described in this inventory conduct some degree of health education and outreach in the Salinas Valley. However, a handful of groups have particularly strong outreach and/or home-based components.

Central Coast Visiting Nurses Association

Central Coast Visiting Nurses Association (VNA) is a nonprofit organization that has been providing in-home care to homebound individuals in the region since 1951. From offices in Salinas and King City, its nurses conducted 70,000 home visits in Monterey and San Benito counties last year. VNA does not track the number of visits made specifically to farmworker families, but they maintain Spanish-speaking nurses in both offices and see many Spanish-speaking patients. The majority of VNA's patients have Medi-Cal or some other form of insurance, and the program serves uninsured individuals through a sponsored care program funded by donations.

Monterey County Visiting Nurse Program

Monterey County's Public Health Department operates a visiting nurse program that delivers evaluations, education, support, and referrals directly to people in their homes.



As the program director explains, “Our visits focus on working with families to build their strengths and self-sufficiency and to prevent long-term problems.” Clients—approximately 80 percent of whom are from farmworker families—are typically teenagers, adult women, pregnant women, new mothers, infants, and children. Each nurse conducts as many as five visits a day. The program’s 200 to 300 referrals each month come from other county agencies, the Central Coast Visiting Nurses Association, and physicians.

Despite the program’s concentration of farmworker clients, only 25 to 30 percent of the fifty or so staff members speak Spanish. Nurses who do not speak Spanish must subsequently rely on family members to interpret.

Through their daily visits to farmworker homes, these visiting nurses have acquired an intimate knowledge of farmworker health and living conditions. They serve people who otherwise might never see a health care professional. However, this important program suffers from understaffing and the ongoing challenge of hiring and retaining bilingual nurses.

Lideres Campesinas

Lideres Campesinas is a nonprofit group that provides health outreach and peer education based on the *promotora* model. *Promotoras* are female farmworkers who are given training and education in order to help them make positive changes in their lives. They then volunteer their time in the community, sharing what they have learned with other farmworker women, usually through workshops in each other’s homes. They also conduct community-based outreach, including presentations and skits. Most of Lideres Campesinas’ *promotoras* are volunteers but the lead workers are paid. The program, which is funded by The California Endowment, is part of a statewide network focused on social and health issues affecting women. Issues addressed include family violence, workers’ rights, lead and pesticide poisoning, women’s health, HIV prevention, nutrition, economic development, and youth issues. In addition, the network is beginning to tackle issues specific to indigenous-language women and seniors. The program also teaches women to recognize domestic violence and sexual harassment and provides peer counseling for victims.

Center for Community Advocacy

Center for Community Advocacy (CCA) is a tenants’ rights group that organizes residents of housing complexes where large numbers of farmworkers live to advocate for improved living conditions. CCA has implemented a *promotor de salud*/health promoter program with funding from The California Endowment, California Wellness Foundation, and Rural Community Assistance Corporation. Through a curriculum designed by the center, CCA tenant committee members were trained to provide health care information and referrals to tenants at their complexes. CCA has so far trained twenty-two male

Lideres Campesinas is a national organization that focuses on community outreach to Spanish-speakers by members of their own communities using the promotora model.



and female *promotores* at fifteen apartment sites, including some with several hundred units. CCA's director notes that "the main difference between this and other *promotora* models is that our *promotores* are already living in the complexes. They know the people there and the people trust them." CCA collaborates closely with Monterey County Department of Health, which has stationed a bilingual licensed vocational nurse at the CCA office. CCA has also designed and administered a survey to assess people's primary health care concerns. The program has been very successful so far, and CCA is considering expanding it within, and possibly outside, the Salinas Valley.

HIV/AIDS Outreach and Education

Lack of knowledge is a primary contributor to the spread of HIV/AIDS among farmworkers. Several programs in the Salinas Valley provide HIV/AIDS education and conduct screenings for members of the farmworker community.

Monterey County AIDS Project offers one-on-one outreach and HIV testing at camps, fields, and other areas where farmworkers congregate.

The nonprofit Monterey County AIDS Project (MCAP) conducts AIDS prevention outreach and education, operates a needle exchange program, and offers counseling, food, practical support, and information and referrals for people with the disease. MCAP's Raza Campesina program targets farmworkers specifically. With funding from The California Endowment, the program conducts one-on-one outreach and HIV testing in Salinas and at migrant worker camps, fields, and other areas where farmworkers congregate. Because farmworkers are unlikely to go to established sites for testing, Raza offers an on-the-spot oral HIV test and provides the results two weeks later.

Monterey County's Health Department also provides HIV testing and administers the AIDS Drug Assistance Program (ADAP), which helps low-income HIV-infected individuals obtain medications. In addition, county workers with the Sexually Transmitted Disease Control Program conduct weekly clinics in Salinas where HIV prevention information is distributed.

Planned Parenthood provides HIV testing and counseling in addition to reproductive health services.

Substance Abuse Programs

A number of substance abuse programs serve farmworkers and their families, including Sun Street Centers, Sunrise House, Valley Health Associates, Interim, Nueva Esperanza, Proyecto Unidad, Rising Eagle, and Trucha. While most offer outpatient services only, some have inpatient facilities and/or transitional housing as well. Virtually all of these programs have Spanish-speaking staff and offer culturally appropriate treatment and counseling for clients and family members.



Alcoholics Anonymous holds meetings in Salinas, Gonzales, Soledad, Greenfield, and King City, several of which are conducted in Spanish. Narcotics Anonymous also conducts a number of meetings in the valley, though none are in Spanish.

According to one substance abuse provider, most farmworkers do not enter substance abuse programs voluntarily. Instead, they are mandated by the courts, generally after being apprehended for driving under the influence. Most attend substance abuse programs for alcohol-related conditions, but a provider noted that farmworkers are increasingly being referred for drug use as well.

Social Service Providers

Community Housing Improvement Systems and Planning Association

Community Housing Improvement Systems and Planning Association (CHISPA) is the largest nonprofit affordable housing developer in the Salinas Valley and Monterey County. CHISPA's housing complexes are often designed with large families in mind, and many include play areas for children and communal rooms for tenant meetings. CHISPA has been active in partnering with other organizations in order to bring services such as health care, education, child care, and grocery stores to residents.

CHISPA has developed more than 1,500 units of affordable housing during the past twenty years, many designed specifically for farmworkers. They are currently developing 100 units of farmworker housing in the San Lucas area. However, housing costs in the Salinas Valley are so high that even CHISPA has difficulty pricing homes within reach of farmworkers. In a recent housing lottery, for example, houses were offered at approximately \$200,000, which is beyond the reach of most farmworkers.

CHISPA also runs the Housing Opportunity Center, a "one-stop-shop" service offering pre- and post-purchase homebuyer education, credit counseling, access to mortgage loans, and access to public agency homebuyer and rental assistance programs for low- and moderate-income people in Monterey County.

Monterey County Housing Authority

Monterey County Housing Authority runs a migrant housing program that operates 215 units of farmworker housing throughout the county. The units are affordable even by farmworker standards. For example, the Casas del Sol complex in Salinas rents rooms accommodating two people for \$175 per month per person or \$250 for a single occupant. The complex also has six well-maintained apartments, each consisting of four rooms plus two bathrooms and a kitchen/living area, a television, a stove, and two refrigerators. There is an onsite laundry facility, and residents can receive mail there as well.

CHISPA administers Monterey County's Housing Opportunity Center, a one-stop housing assistance program for farmworkers.



Most residents are migrant farmworkers who do not live at the complex year-round, but some migrant workers continue to pay rent in order to keep their rooms while they are gone. Unlike the USDA's Farm Labor Program, which requires farmworkers to be documented and working directly as field laborers, these complexes also accept undocumented workers and people who work in agriculture-related industries such as packing sheds and processing plants.

Shelter Outreach Plus

Shelter Outreach Plus is a nonprofit organization that provides the majority of homeless services in Monterey County. Among its offerings are a twelve-unit battered women's shelter in Salinas that houses up to sixty people; the Interfaith Homeless Emergency Lodging Program, which provides homeless men with emergency shelter at local churches; a transitional housing program offering very low-cost housing to homeless women and children for up to two years; a bilingual twenty-four-hour crisis and referral hotline with information about housing, employment, and other services; and counseling and case management to help people who currently rely on the shelter and transitional housing to become self-sufficient.

Housing Advocacy Council of Monterey County

The Housing Advocacy Council of Monterey County is a nonprofit organization that offers rental assistance to people trying to obtain housing or avoid eviction. Services include emergency rent money, long-term payment plans for security deposits, assistance with first-month rent, move-in assistance, and workshops for first-time homebuyers and tenants on available programs and money management.

Catholic Charities

Catholic Charities provides farmworkers with emergency assistance for rent and utilities. An informant notes that the demand for those services among farmworker families surges dramatically in the winter as field work wanes.

City of Salinas Homebuyer Program

The City of Salinas has a first-time homebuyer program that provides low-income families and individuals earning 80 percent or less of the city's median income with low-interest (3 percent), deferred payment loans for the purchase of a first home. The program, begun in 1994, has provided 177 families with loans so far. Farmworkers comprise 28 percent of the recipients. The program's budget for the 2004–05 fiscal year is \$650,000, which will fund homes for fifteen families. According to a program representative, sixty to seventy-five families apply to the program annually but many of them are not eligible

The city of Salinas provides loans to low-income residents for first-time home purchases.



because of their existing debts. Applicants with poor credit are referred to the Housing Opportunity Center for credit counseling and assistance.

Loans to residents of Salinas are generally available for up to \$40,000, but residents of the Alisal Strategy Area on the city's east side are eligible for up to \$50,000, thanks to the city's efforts to facilitate home ownership in that neighborhood. Eleven of the seventeen loan recipients in that area (65 percent) were farmworkers. However, since the program is only authorized to provide loans for homes costing up to \$281,000, purchases are essentially limited to condominiums and "fixer-uppers," the only dwellings in that price range in Salinas.

Women's Crisis Center

The Women's Crisis Center initiated the Farmworker Project in March, 2002, with funding from The California Endowment. The center, located in Salinas, offers outreach, education, counseling, and support for female and male victims of domestic violence. Assistance includes helping people file for restraining orders, accompanying victims to the hospital and court, and immigration advocacy for undocumented victims whose spouses are legal U.S. residents. The program also provides outreach and education to the community by way of presentations in the fields and at health fairs and other community settings, radio addresses, newspaper op-ed pieces, and training for health care providers and health promoters. The Farmworker Project provides direct services to several hundred people a month, and staff members estimate they reach several thousand farmworkers each month when all outreach efforts are taken into consideration.

Domestic violence can result in problems related to immigration status when the victim is an undocumented immigrant married to a legal resident.

The Citizenship Project

The Citizenship Project provides a broad range of immigration services for farmworkers, including helping undocumented victims of domestic violence who are married to legal residents remain in the U.S.

Youth Programs

Barrios Unidos, Second Chance, Partners for Peace, and the Police Activities League focus on youth and gang violence prevention. Sunrise House and Sun Street Centers attend to substance abuse. In addition, various cities' parks and recreation programs work to educate and engage young members of the farmworker community. POSTPONE, a community partnership with Salinas and south county components, works to prevent teen and unwed pregnancies, reduce the number of fatherless children, and promote responsible parenting and fathers' involvement in the economic, social, and emotional support of their children. The county's Migrant Education Program endeavors to help migrant youth complete high school by providing services that include emergency medical and dental



care, non-emergency health referrals, classes in English as a second language, GED preparation, job training, and transportation to needed services.

Collaborative Activities in the Salinas Valley

There is a high level of collaboration among health and social service providers in the Salinas Valley. In addition to collaborations focused on specific projects, there are several ongoing collaboratives bringing providers together to improve the health and well-being of farmworkers and other Latinos in the Salinas Valley.

Latinos Issues Coalition

The Latino Issues Coalition is a collaborative of approximately sixty-four health and social service providers. The coalition works to develop program and policy agendas around improved health and social services for Latinos in the Salinas Valley. The coalition began in 1988 as a small group of health-related organizations serving as an advisory committee for *Impacto I*, a Latino behavioral risk survey conducted by the Monterey County Health Department. The group has grown considerably over the years and has incorporated many social service providers as well. It recently changed its name from the Latino Health Coalition to the Latino Issues Coalition in order to reflect the coalition's broader focus.

A number of collaborative efforts are already under way in the Salinas Valley to assist farmworkers and their families, particularly those who live in the southern part of the county where services are few.

Latino Social Work Network

The Latino Social Work Network (LSWN) is a collaboration of Latino mental health and social service providers. Most are county employees, but membership is open to all providers. LSWN offers providers an opportunity to network and learn to better serve Latino clients through monthly luncheons featuring speakers on a broad range of relevant topics and a large annual gathering. The network also has been making concerted efforts to bring Salinas Valley providers information to which they might not otherwise have access. For example, they are currently exploring the possibility of hosting a "mini" Latino Behavioral Health Institute conference in Salinas, since many providers could not attend the institute's main conference in Los Angeles.

South County Regional Health Partners

South County Regional Health Partners brings together approximately thirty health care providers, school district and community agency personnel, elected officials, and employers. The goal is to increase access to health care for residents of southern Monterey County, particularly those in outlying areas where geographic constraints and a lack of public transportation sharply limit access. The collaboration just launched a mobile health clinic that will serve the south county hamlets of San Lucas, San Ardo, and Lockwood.



South County Outreach Efforts

South County Outreach Efforts (SCORE) is a coalition of outreach workers from health and social service agencies in southern Monterey County that advocates for improved service delivery to residents of this traditionally underserved area. It is particularly focused on transportation, pesticide awareness, citizenship education, health education, education services, and disability awareness.

Safe Schools / Healthy Students

The Safe Schools / Healthy Students Initiative is a nationwide program built on regional affiliates. The Salinas group consists of personnel from several school districts and fifteen public sector and community-based agencies and organizations associated with mental health, social services, law enforcement, and juvenile justice. The initiative promotes healthy childhood development and prevention of youth violence and substance abuse.

Monterey County Housing Alliance

Monterey County Housing Alliance is a public-private partnership consisting of representatives from CHISPA (see above), Housing and Urban Development, Fannie Mae, Freddie Mac, Congressman Sam Farr, lending institutions, Monterey County governmental agencies, the City of Salinas, and a number of community-based organizations. The goal of the partnership is to improve housing opportunities for low-income residents of the county by providing access to affordable housing, homeowner and rental education, and credit counseling. One of the alliance's contributions is the one-stop Housing Opportunity Center previously described under CHISPA.

Health fairs are an effective form of collaboration that brings health information and screenings to large numbers of farmworker families.

Additional Collaborative Efforts

Frequent health fairs in the Salinas Valley bring together a wide swath of health and social service providers to offer health education and screenings. The fairs are often accompanied by flea markets, which attract a broad range of residents.

There are numerous other ongoing efforts to educate providers about health and other issues facing farmworkers and the Latino population in the Salinas Valley. For example, a coalition of providers, spearheaded by the Community Action Agency, hosted a two-day Latino health symposium during Binational Health Week. The highlight of the event was a one and a half day presentation by two indigenous-language physicians from Oaxaca, who provided an in-depth overview of indigenous speakers' health-seeking beliefs and behavior.

Principal Health Conditions

The most frequently cited physical health conditions cited by farmworkers, physicians, and other informants are diabetes, cardiovascular disease, obesity, and asthma and other



upper respiratory problems. Providers often associate diabetes, hypertension, and obesity with poor diet, lack of exercise, and stress.

Diabetes

Diabetes is by far the most commonly reported condition affecting farmworkers. Providers cite a disturbing increase in cases of diabetes in recent years, particularly Type II (adult onset) diabetes among children and youth, as a Salinas physician noted.

The main health problems we see are more diabetes at a younger age in patients that are not at risk. They are not obese or old. We see fifty patients a day and diagnose two to three new cases of diabetes a week, which is a high rate.

This concern was confirmed by a physician in Gonzales.

We've seen an explosion in Type II diabetes in Gonzales in the past ten years. We find three or four diabetics out of every fifty to seventy-five that get screened. Most of those people have no idea they have diabetes. We've been seeing a big increase in diabetes among children and teens. The diabetes is in part due to a genetic predisposition, but is also influenced by diet. People's diets have gotten increasingly worse over the years. Many parents give their kids lots of sweets and junk food. When I tell them not to give their kids junk food, they say their kids cry or throw a fit. I tell them "Who's the parent? It's your responsibility to make sure your kids are eating well."

A physician from Natividad Medical Center described the serious medical complications associated with diabetes.

[Diabetes] is a leading cause of adult blindness. It also accounts for 40 percent of all cases of kidney failure, with very expensive dialysis treatment. People with diabetes are also two to four times more likely to have a heart attack or stroke.

An administrator at Mee Memorial Hospital discussed their efforts to address vision problems that are often associated with diabetes.

We started bringing an ophthalmologist in on Fridays and Saturdays about three months ago. He sees about twenty patients a day. Most of the vision problems we see are due to diabetes. Eye care is critical because of diabetic retinopathy. It's a leading cause of blindness and requires close monitoring by an ophthalmologist. This is an important service, because specialty care is often unavailable to farmworkers if it's not nearby, since many don't have transportation and can't afford to take the time off work.

Treatment regimens for diabetes can be complicated and expensive. Quality care includes not only insulin but also frequent and expensive tests, as a physician in Salinas noted. "For example, the hemoglobin test costs \$63, which must be done monthly."

In many cases, behavior modification is all that is required to successfully treat diabetes, but patients find it difficult to change their behavior, as a physician observed.

We can treat diabetes without drugs, just by changing habits. Improved diet and exercise are still the mainstay. Children have modifiable risk factors, including obesity, low levels of exercise, and high fat/low fiber diets. We need to

Diabetes is a very common condition among Hispanics, and farmworkers' lifestyles and limited access to services make it difficult to effectively diagnose and treat them.



change those behaviors among children. For example, they need to walk more. Doctors need to keep hounding people about behavior change.

Childhood Obesity

The Salinas Valley joins the nation in witnessing a surge in childhood obesity. A physician assistant at a Gonzales clinic explained the disturbing trend there.

We recently treated a five year old who weighed 117 pounds. We also recently treated a fourteen year old who had knee problems because he was so heavy. There was also a seventeen year old with high blood pressure and cholesterol. He's already at high risk, especially because he had a relative who died of a heart attack at the age of forty-one. We shouldn't be seeing problems like this among such young kids.

A physician at the same clinic explained that obesity is directly associated with diet.

We've seen a huge surge in obesity along with an increase in poor eating habits. People here are eating lots more fast food—some families go to McDonalds three to four times a week. . . . The biggest need we have right now is for a nutritionist to come to the clinic and teach people about a healthy diet and explain how bad junk food is for them and their kids.

These observations are corroborated by *An Epidemic: Overweight and Unfit Children in California*, a recently released report from the California Center for Public Health Advocacy. The report found that the Salinas Valley has one of the highest percentages of overweight children in California. Fully 35 percent of fifth, seventh, and ninth grade children in the region are overweight, compared with 27 percent statewide. Forty-one percent of Latino children in the region are overweight, compared with 24 percent of white students. The report also described the many medical and mental health conditions associated with obesity.

Overweight children face a greater risk of a host of problems, including Type II diabetes, high blood pressure, high blood lipids, asthma, sleep apnea, chronic hypoxemia, early maturation, and orthopedic problems. Overweight children also suffer psychosocial problems, including low self-esteem, poor body image, and symptoms of depression. Because overweight children are likely to become overweight adults, these children are more liable to suffer from cardiovascular disease, cancer, and diabetes in adulthood—all chronic, but largely preventable diseases that already account for two-thirds of all deaths in California.

The rise in obesity is also due to a lack of physical exercise. Numerous providers commented on the lack of recreational opportunities and parks for children in the Salinas Valley. According to the *Kid Friendly Cities Report Card*, Salinas has only 3.6 acres of parks per 1,000 persons, compared with 12.1 acres for other cities in the same size category.²⁶ Some informants have noted that children are at times afraid to use existing parks because of concerns about gang activity.

The Salinas Valley has one of the highest rates of childhood obesity in California.

²⁶ <http://www.kidfriendlycities.org/2001/city89.html>.



Childhood Lead Exposure

Informants reported that lead poisoning is not a particularly serious problem among children of farmworkers. According to the *Monterey County 2002 Health Profile*, there were 17.9 reported cases of lead poisoning per 100,000 children under the age of six between 1996 and 2001. However, while California's rate declined 16 percent between 1991 and 2001, Monterey County's rate increased by 46 percent during the same period.²⁷ Lead poisoning data are not tabulated by ethnicity, but a source at the Health Department reports that most cases of childhood lead poisoning occur among Latinos.

Children are not the only ones at risk from lead exposure. A nurse at the Comprehensive Perinatal Services Program at Alisal Health Center reported high levels of lead among the pregnant women she sees, explaining that exposure "could be from cooking pots used in Mexico or from the water there, which may be contaminated with lead." Lead is also found in some Mexican folk remedies used for *empacho*/upset stomach, which some farmworkers still use.

Lack of Preventive Health Care

Many providers stressed that the most important means of improving farmworker health is through a focus on prevention and on promotion of healthy lifestyles, including improved diet, increased exercise, and reduced alcohol consumption.

The number one need to improve farmworker health is education about prevention. Farmworkers suffer from many diseases that could be avoided through prevention, especially diabetes and heart disease.

Numerous studies have documented that Latino immigrants' diets tend to become increasingly unhealthy the longer they remain in the U.S., with subsequent increases in cancer, hypertension, diabetes, obesity, and other "western diseases."²⁸ The Salinas Valley is no exception in that regard. The Monterey County Department of Health conducted the Monterey County Hispanic Behavioral Risk Assessment (also known as *Impacto II*) in 2000, which surveyed more than 1,000 Latino residents, including a sample of 188 men living in agricultural labor camps. Findings from that study document the association between years lived in the U.S. and unhealthy behavior.

Especially high fat/fast food intake and alcohol consumption in the agricultural camp sample increased with the length of time respondents had lived in the U.S. Many Latinos come to the U.S. with good health behaviors, but are negatively influenced by this "fast food nation."

Latino immigrants' diets tend to become increasingly unhealthy the longer they remain in the U.S., a grave risk to a population already at risk to develop diabetes and hypertension.

²⁷ Some sources believe that the increase is due to improved surveillance, as opposed to an actual increase in lead poisoning.

²⁸ CIRS, California Agricultural Workers Health Survey (CAWHS).



Highlights of the study's principal findings include:

- One in five respondents had not eaten any fresh fruits or vegetables on the day before the survey.
- Men in agricultural labor camps were most likely to eat red meat, fried food, fast food, and high fat snacks regularly and to binge drink, defined as five or more drinks on one occasion.
- More than 20 percent of all respondents were obese, while more than 60 percent were overweight.
- One in three men and half of all the women failed to engage in recommended levels of physical activity.²⁹
- On a positive note, 20 percent of men and only 7 percent of women reported smoking cigarettes (Latinos have the lowest rates of death from lung cancer of any ethnic group in the U.S.).
- Also positive is the 20 percent increase in women reporting having had a pap smear during the past year and the three-fold increase in women reporting having had a recent mammogram.

Living and working conditions common to farmworkers tend to drive them toward fast food diets that are high in fat and low in nutrients.

Providers report that many farmworkers do not realize that consuming fast food on a regular basis can result in obesity, diabetes, and heart problems, or that foods such as ramen noodles—which are extremely popular among farmworkers because they are inexpensive and easy to prepare—are very high in fat and sodium. Nonetheless, health promotion efforts are having an impact and attitudes about diet are changing. Many farmworkers demonstrated a clear understanding of the importance of eating a diet low in fat and high in fresh fruits and vegetables.

In order to stay healthy I try to not eat fat. I eat vegetables and I don't eat a lot of meat. I also make vegetable juices; I have a machine that makes juices.

I try to buy fruit and vegetables to keep my family healthy. For instance, in the morning I give my daughter a shake that contains fruit. I also try to steam food and not fry as much.

[Since being diagnosed with diabetes] I no longer eat red meat, pork, or tortillas. I've developed a taste for herbal teas instead of coffee. I also make white rice instead of Mexican rice. I eat vegetables every day. I also eat whole beans and don't re-fry them anymore. Plus, I drink a lot of water. I've only changed my eating habits since July. My husband hates it!

Some farmworkers explained that life in the U.S. has improved their diets in some ways, but made them worse in others.

I buy a lot of fruit and try to give my family vegetables. At WIC, they told me that we have to eat more vegetables. I think that we eat more healthily here, because here I can give my kids more fruit and more healthy foods. But they also eat more junk food here too, like chips and stuff like that.

²⁹ While agricultural labor is clearly physical work, many tasks are not considered aerobic as they do not result in elevated heart rates.



Because people have no insurance and cannot afford to pay cash, they forego health care until conditions become too serious to ignore.

Some farmworkers expressed a desire for more of the natural foods they ate in Mexico. A farmworker explained that “here in the United States you eat better, because you have money to buy food” but lamented that:

In the U.S., there is nowhere to grow your own food and nowhere to raise your own chickens. Here, we have to buy meat in the supermarket that has hormones in it. In Mexico, we fed our chickens natural food and they were better.

Other factors can impede people’s efforts to adopt healthier behavior. Farmworkers living in overcrowded and/or substandard conditions often do not have adequate kitchen facilities. Many solo males may not know how to cook, and most farmworkers have limited time for preparing meals or for exercise. Fresh fruits and vegetables can be difficult to obtain, particularly in small towns, despite the valley’s vast agricultural economy. Cultural preferences for a diet high in fat and salt and marketing of fast food, sodas, and other junk foods, to which children are especially susceptible, make it difficult not to indulge. Parks and other recreational facilities are in short supply, and for many, alcohol is the only readily accessible form of entertainment and socialization.

Early detection of disease is another critical component of prevention campaigns. Many farmworkers do not receive regular checkups or seek timely treatment for illnesses because they lack the time or money to do so, not because they are not concerned about their health.

If I had all the resources available to me and money were not a problem, I would get an overall checkup of my body. It’s good to have yourself checked out so that you can prevent diseases. Sometimes we don’t get checked due to lack of money or because we don’t know how to go about getting help. Then it’s worse.

In addition, since farmworkers are not paid for sick days, they are reluctant to take time off for routine checkups. According to a local physician,

Many people wait until they’re very ill before seeing a doctor. These are very hard working people, and it’s more important for them to make sure they have a paycheck than to take time off to see a doctor.

As a consequence, many diseases are not detected until they are advanced. A physician assistant explained that “we need to teach people to recognize small problems and have them taken care of before they become a medical crisis and people need to be hospitalized.”

A Salinas physician cited the considerable savings for health care systems generated by early diagnosis of chronic and other diseases.

Early diagnosis and treatment will also result in high cost savings over time, as we prevent complications such as blindness and renal failure that are associated with diabetes. As you may know, dialysis is currently the single largest health expense in the United States.



Despite this potential benefit to health systems, *Impacto II* found that many health care providers do not ask farmworkers about easily identifiable risk factors such as high fat diets and heavy drinking, highlighting the need for providers to play a more proactive role in identifying and counseling high-risk individuals.

Reproductive Health

Birth rates for Latinas in Monterey County in 2001 were 29.3 per 1,000, more than three times higher than the rate of 8.7 per 1,000 white women.³⁰ Additionally, 25 percent of Latinas do not receive prenatal care during the first trimester of pregnancy—a lower rate than any other ethnic group in the county.³¹ These data probably understate the extent of the problem among farmworker women, many of whom are recent arrivals from Mexico who access services less frequently than more settled immigrants or women born in the U.S. Least likely to receive prenatal care are Oaxacan women who have limited experience with any kind of formal health care. According to a health care provider, “Oaxacan women often show up at our doorstep in labor. Many still use traditional healers, whose practices are sometimes deleterious.”

Poor prenatal care is associated with low birth weight,³² which is in turn linked to inhibited growth, reduced cognitive performance, and greater morbidity among children. While no specific data were available for farmworker infants, 17 percent of all infants born at Natividad Medical Center in 2000 were reported as low or very low birth weight, compared with 7 percent for both Monterey County and for California.

While teenage pregnancy is declining nationwide, many informants noted a disturbing increase in the Salinas Valley. An in-house study conducted by Clínica de Salud determined that 85 percent of its recent obstetrics/gynecology patients were teenagers, and a physician reported fifteen teen mothers in the small town of Gonzales the previous year. Young women from indigenous-language areas often become pregnant at very young ages, as the director of Public Health’s nursing program noted.

There are a lot of teen moms among the Oaxacans—girls as young as thirteen or fourteen having babies. This often creates conflicts, because it’s okay to be married at thirteen in Mexico, but not here.

Mental Health

Many informants emphasized that mental health problems, including depression, stress, and anxiety, are major health issues affecting farmworkers. It is difficult to precisely measure the extent of these problems because there are so few avenues of access to services,

Women from indigenous-language areas of Mexico generally have little experience with formal health care of any kind, so they do not seek prenatal care when they become pregnant.

³⁰ California Department of Health Services, Center for Health Statistics, <http://www.applications.dhs.ca.gov/vsq/>.

³¹ Monterey County Health Department, Health Profile 2002.

³² Babies weighing less than four pounds (2,500 grams) at birth are considered low birth weight, while those under 1,500 grams are considered very low birth weight.



but it is clear that the farmworker community increasingly recognizes and acknowledges the need, as the director of Community Action Agency noted.

When we did the Farmworker Housing and Health study, 48 percent of the people in our survey said they would like some kind of mental health assistance. That's pretty high. When I talk to women's groups, they always say "*siento ansiedad*/I'm anxious" and "*me siento mal*/I feel bad," so it's definitely clear that people need some kind of mental health assistance to help them deal with the issues they're facing in trying to survive. They might have money for food this week, but who knows what next week is going to be like?

Numerous social and cultural factors contribute to mental health problems in farmworker communities. Certainly one primary stressor is poverty. Many farmworkers struggle to survive from paycheck to paycheck, with mounting bills and threats of eviction and impending homelessness. One farmworker tearfully explained her situation. "I feel very nervous and pressured here in the U.S. I owe everyone and am constantly living in fear that I can't pay all the hospital bills that are piling up." Debt can also create a complex cycle of borrowing from friends and family to pay other creditors, as another farmworker noted.

The pressures engendered by poverty are an enormous source of anxiety and stress for farmworker families.

The hardest times I've faced are when we don't make enough to pay the bills. The hours and pay are not set, so even though there may be no work, we still have to pay the rent every week. When we don't have enough to pay the bills, we have to ask friends for help. Usually our friends are good at fronting us the money until pay day, but if we don't have the money then, we have to borrow from other people so we can pay our friends back. The whole cycle of borrowing money to pay the bills and borrowing to pay the friends who lent us money is very stressful.

Farmworkers may also experience feelings of hopelessness and despair when dreams of "the promised land" do not materialize, as a member of *Lideres Campesinas* explained.

Many women suffer from depression. They have money problems, bills piling up. My water has been cut off four times this year alone. People come here looking for a better life and get depressed when life is not better. They think "*esta es mi mejor vida?*/is this my better life?"

Beyond the direct effects of cash flow, the feast or famine cycles of agricultural labor also induce anxiety. Farmworkers work very long hours during peak season, with little time to relax or socialize, which can lead to stress and the disintegration of important family and social networks. Conversely, families who remain in the valley in the winter are generally unemployed. They have free time but little money, generating considerable pressure. A priest in Castroville described the difficulties unemployment at any time of year can cause.

Domestic violence goes up with stress, which can result from poverty, a bad economy, or being without work. Men feel inadequate and their wives complain more. We see more of that in the off season when there's no agricultural work; the men are home more, the bills are piling up, and they're bored and frustrated.



Many farmworkers also suffer from loneliness and isolation, particularly solo males who have left spouses, children, and other relatives behind. This experience has become more common as stricter border controls make it more difficult to return to Mexico for visits. In addition, a number of immigrants described harrowing border crossings that have left them with post-traumatic stress disorders.

Undocumented immigrants often suffer from anxiety about being apprehended by the Immigration and Naturalization Services (INS), known as *la migra*.

La migra affects me in my daily life, but I try not to think about it so I can be calm around my kids. When you're working, you worry about the INS. I get scared that they're going to take me away and then my kids will be left on their own.

A documented farmworker expressed her concern for others.

Personally, the INS doesn't affect me, because I have my papers. But I get so sad for those who don't have their papers. In Chualar, you always see the INS. One time, the year before last, they took three ladies and a man away.

With such a high incidence of stress and anxiety, people inevitably suffer physically. A local priest described the connection between physical ailments and mental health. "People's physical health suffers when they have poor mental health. Stress lowers your immunity and makes you more susceptible to illness."

An additional source of stress derives from identity issues that affect many children of immigrants, as the priest at the Castroville church, himself a child of farmworkers, explained.

Farmworker children are caught between two worlds, two cultures and two identities that often seem incompatible. They often do not see themselves as Mexican-American. Rather, they do not feel Mexican and do not feel American. This results in a lack of a sense of identity and a lack of pride and self-esteem. It can also lead to self-destructive behaviors in the form of drug use, premature or irresponsible sexual activity, and gang affiliations.

The main portal to mental health services for children is referrals from counselors at school. A counselor at Alisal High, which has a large farmworker population, noted gender differences with respect to children's access to mental health services. Boys tend to act out more and are subsequently more likely to be referred for mental health counseling. Conversely, girls, who have a greater tendency toward depression, are more likely to be overlooked and less likely to receive mental health services.

Undocumented workers tend to suffer from even greater isolation because their fear of INS enforcement prevents them from moving freely in society.



Social Problems

Violence/Community Safety

Violence is a concern in the Salinas Valley. A survey found that only 20 percent of men living in farmworker camps felt safe there and that nearly half of the men felt that the number of violent incidents was increasing.

In a study of criminal statistics in California, Salinas was designated as one of the eight most violent mid-size cities in the state in 2000.³³ Salinas Police Department data indicate that the city's east side, where large numbers of farmworker families reside, experienced particularly high rates of crime and gang violence in 2002. *Impacto II* found serious concerns about violence among men residing in agricultural camps: whereas nearly 40 percent of men in the community sample reported feeling “very safe” from violence in their neighborhoods, only 20 percent of those in agricultural camps felt similarly secure. Additionally, the study reported that “almost half of the men in the agricultural camps thought that the amount of violence had increased in the past year, compared with about 10 percent of the community sample.”

Gang violence is prevalent in Salinas and nearby small towns. Some providers attribute this to young people seeking what they do not get at home, primarily a sense of belonging and self-importance. The sense of belonging that gangs generate can be especially appealing to young people caught between an unfamiliar and sometimes hostile dominant culture and disdain for their own roots.

Domestic Violence and Child Abuse

Some providers believe domestic violence affects only a small percentage of the population, while others feel that the majority of farmworker women are or have been victims of some form of physical, emotional, verbal, financial, or other abuse. Few male or female farmworkers interviewed as part of this study openly discussed domestic violence, and very few admitted to being victims or perpetrators.

A staff member at the Women's Crisis Center described her beliefs about the roots of domestic violence.

The main factors contributing to domestic violence are machismo, poverty and associated money problems, alcohol and drugs—particularly cocaine and crank—and the stress related to those issues. When men are mistreated in the fields, they abuse their wives at home. Jealousy is a big issue for men as well.

The Women's Crisis Center and religious leaders are trying to counter cultural beliefs regarding domestic violence and abuse. A Catholic priest in Greenfield, for example, tries to increase the self-esteem of women in the farmworker community, reminding them of their dignity and preaching the need for respect for women. Similarly, a priest in Castroville noted the connection between domestic violence and self-esteem. “Women don't complain and are often in denial about being victims . . . They feel they deserve it. They're co-dependant. We need to raise women's consciousness around that.”

³³ Sourcebook of Criminal Statistics, 2000.



It is often difficult for women in farmworker families to get out of abusive relationships, as a provider with the county's Domestic Violence unit explained.

It's difficult for many women to leave their husbands, because then they're left without an income. Also, many families don't support women that are victims of domestic violence. That's true for family members on the women's side as well. They don't see it as a problem or a valid reason for leaving your husband.

Employees at the Women's Crisis Center noted that many women do not understand the considerable differences between Mexican and U.S. laws associated with domestic violence.

Many women in abusive situations are afraid to leave their husbands, because leaving your husband is a crime in Mexico. It's called *abandono del hogar* [abandonment of the home] in Mexico, and a woman can lose her home and children for that. However, many women don't realize that's not a crime in the U.S.

Immigration status figures prominently in decisions to leave abusive relationships, particularly for those who are married to citizens or legal residents, but whose own immigration status is still pending.

Men are also victims of domestic violence. A representative of Catholic Charities noted that their counseling program sees "a number of men that are battered," as do staff at the Women's Crisis Center.

We've seen seven such men [victims of abuse] so far, but that's just the tip of the iceberg. It's mostly mental, emotional, and verbal abuse in those cases. In some cases, women abuse their children as a way of abusing their husbands.

Several providers reported that domestic violence is more difficult to address with indigenous-language populations. As a staff member at the Women's Crisis Center noted,

Indigenous women have it even worse. There are no boundaries around age issues. In Oaxaca, it's normal for twelve-year-old girls to be married. It's not considered statutory rape if they're already married, but most are not legally married. Indigenous women are also less likely to ask for help. . . . it's hard for them to believe that domestic violence is not okay.

Language barriers can also impede the delivery of services to this population.

The Oaxacan population presents its own set of difficulties. They speak several dialects, and there are problems with translation and confidentiality. We don't have any translators on staff, so we have to use local people. For example, for a woman to get a restraining order or hospital accompaniment, she has to give a declaration of what happened. That presents confidentiality problems, and she may not want someone she knows to hear her declaration.

Cultural beliefs and language barriers make it particularly difficult for providers to intervene in cases of domestic violence among indigenous-language couples.

Views about the extent of child abuse are more diverse. On one hand, a representative of Child Protective Services suggested that "child abuse is a major problem in the farmworker community; there is a big need for parenting education, especially for very young parents." A youth advocate also expressed the opinion that child abuse is common. "Many children talk about getting hit. There's also a lot of mental abuse, which in some ways is just as much of a problem, since it leads to low self-esteem among kids." On the other



hand, there are providers who believe that the issue is more one of neglect than of abuse. A priest from a parish in Greenfield agrees. “There is more neglect of children than outright abuse. Kids are left alone too much. They spend too much time in front of the TV.” A school official who believes that child abuse is not a big problem corroborates these observations. “We have approximately one child abuse report per month out of a population of 2,100 kids.”

Familial Conflicts

Informants note a high degree of concern among farmworker parents regarding conflicts with their children. Parents often complain that they cannot control their children, whom they perceive as disrespectful and possessing different values from their own. They often lay the blame for these conflicts on their decision to come to the U.S. Many parents also blame child abuse laws that prohibit them from disciplining their children physically. As the director of a substance abuse program in Salinas explained,

A lot of older people say why did we ever come here? Our kids didn’t have the same freedoms in Mexico. I used a belt on my kids in Mexico and it was considered discipline, but here they arrest me.

Substance Abuse

While informants debate the prevalence of drug abuse among farmworkers in the Salinas Valley, virtually all agree that males tend to consume too much alcohol. The prevention director of Sun Street Centers, a local substance abuse program, outlined the problem.

Alcohol is very accessible—people use it to find relief from pain and depression. A lot of people already come here from Mexico with alcohol problems. It’s not like it started here. Does coming here make it worse? The answer is probably yes, if coming here doesn’t make people’s lives better, or if assimilation leads to more drug use. Also, people have more money to buy beer, and kids have more money too, for buying alcohol and drugs.

Many informants cited high levels of drug use among farmworkers as well, which some attribute to depression and despair. As a provider explained, “Poverty promotes depression, which leads to substance abuse. It’s easy to suffocate it all with drugs.” Others believe that farmworkers use drugs primarily to relieve pain and/or get energy to work longer or faster. A physician cited anecdotal data about high levels of substance abuse among those working in the lettuce fields, a particularly demanding job. The prevention director at Sun Street also reported that farmworkers are increasingly using prescription and nonprescription drugs to control pain so they can continue working despite injuries. A celery worker described this type of substance use.

We work very fast and very hard. We use alcohol, marijuana, and cocaine so our bodies can bear it. I work ten hours a day. Do you think you can work all those hours bent over cutting celery every single day? Not a lot of people can do that.

A farmworker and an ex-farmworker described their views of drug use in the community.

Physically demanding jobs, poverty, and isolation all raise the risk of alcohol and drug abuse among farmworkers and their families.



I've heard of people using cocaine to help them work. Farmworkers use all kinds of stuff, like marijuana, coke, crystal, and crank. People that don't use those drugs use liquor and alcohol. I don't do that because it's very dangerous to be drugged up and working with big knives like the ones we use. A drugged out person can injure you at work.

I tried a lot of crystal and cocaine when I worked in the fields. Crystal is the most common drug among farmworkers, followed by cocaine and marijuana. . . . A person can spend \$100 on crystal [methamphetamine] in a weekend. I would say about 40 percent of farmworkers use crystal. It's mostly the younger ones, hardly the older ones. The older ones mostly drink beer. But I wouldn't say they're alcoholics. They drink a normal amount, maybe a twelve-pack on the weekend.

Given the lack of recreational outlets, drinking is also a form of entertainment, as a young farmworker explained.

For entertainment I drink with my friends or by myself. Basically, that's what you do. There's nothing else to do. I've been drinking since I was a little kid. They started by giving me *charanda*/aged white alcohol. I spend about \$100 a week on alcohol. . . . Farmworkers also use drugs. Marijuana mostly, and sometimes cocaine. People use cocaine so that they can work faster. . . . I started using marijuana when I was thirteen years old and I haven't stopped. I pay about \$60 for an ounce of marijuana, which lasts me a week. It's not hard to get.

There is no clear consensus among providers regarding the extent of drug use among youth. Some feel the issue is a "time bomb" waiting to explode; others believe that its prevalence has been blown out of proportion. Providers report that marijuana and ecstasy are both popular among youth. Sun Street's prevention director believes that drug and alcohol abuse among young people is increasing and that methamphetamine use is a particularly serious problem.

There's been a big increase in meth use. It's the "silent drug." Nobody wants to talk about it, but it's on the verge of taking over. It's a very addictive drug. We're seeing sixteen and seventeen year olds, and even twelve to fourteen year olds, taking meth. It's a way for kids to escape their problems at home. . . . Meth is very available. It's cheap and easy to make. . . . You can get the ingredients at any farm supply store. However, they also add Ajax, talc, and other toxic substances to stretch it.

However, she noted that alcohol is still the most prevalent form of substance abuse among youth.

Alcohol is still the drug of choice for high school age teens. According to surveys, about 60 to 65 percent of teens abuse alcohol . . . and 40 percent use marijuana. The survey didn't ask about meth use, because it wasn't a big issue in 1998 . . . Kids usually start with alcohol and then move on to meth . . . which is the quickest high. Also, meth use is associated with an increase in crime. Data from King City show an increase in robbery and assaults with an increase in meth use. I'm on the drug court committee. The drug court and juvenile hall are seeing an increase in meth use and dual meth/other drug use.

The principal of Alisal High, a large high school in east Salinas that is purported to be the toughest school in town, believes that substance abuse among her students is relatively

Farmworkers report using prescription and nonprescription drugs to combat painful injuries and enhance their endurance.



Lack of familiarity with the U.S., poor English skills, low incomes, lack of health insurance and benefits, and providers who are not linguistically or culturally competent all impede access to health care for farmworkers.

low, at least while on campus. The school conducts random drug searches using specially trained police dogs and rarely finds drugs. However, other school staff members believe the problem is more serious. They cite examples of students coming to school on drugs or with alcohol on their breath. According to the director of Sunrise House, a substance abuse prevention program serving youth, the prevalence of drug use among young people in Salinas is the same as anywhere else in the U.S.

Most kids in our community are basically good kids. Some may experiment with drugs and alcohol. There's always a small percentage we're going to lose. Salinas is no worse than anywhere else. I taught at Alisal High for fifteen years and was the coach there for twenty years. If you go into that school, it doesn't feel any different from any other school. The halls are quiet and the kids are well-behaved and respectful. Any of those kids will be happy to take you to the principal's office.

Barriers to Care

Farmworkers in the Salinas Valley face numerous barriers to obtaining access to health care, including a lack of insurance, financial constraints, lack of transportation, and language barriers. For newly arrived immigrants and others with limited English skills and little experience with U.S. institutions, even relatively mundane tasks can be complex. The job of finding a provider is more complicated—the ideal provider will speak the same language as the patient, work in the same community, and understand and respect the sociocultural context of the ailments the patient describes. Establishing insurance coverage involves a paperwork intensive, bureaucratic application process that must be repeated periodically. Referrals to specialists introduce another layer of administration, paperwork, geography, and expense. And this intricate system must often be navigated without the benefit of a telephone or a car.

The following sections describe some of the health-related attitudes and practices of farmworkers and providers, deficits in community infrastructure, economic constraints, labor practices, and institutional policies that impede the delivery of health care services to farmworkers and their families.

Cost of Services and Lack of Medical Insurance

Survey data indicate that between 6 and 19 percent of farmworkers in California have employer-provided health insurance, while an estimated 60 to 70 percent of heads of households in the farmworker community have no insurance at all, including public programs such as Medi-Cal.³⁴ The cost of health care is a major deterrent for farmworkers lacking full insurance coverage. Most clinics charge from \$40 to \$65 per visit, a day's take-home pay or more for most farmworkers. *Impacto II* found that 50 percent of men living in farm labor camps had not seen a doctor in two years. More than 60 percent of

³⁴ These statistics are from the NAWS, BFHS, and CAWHS data.



these same men lacked health insurance and could not afford to see a doctor or buy a prescription in the past year.

Although providers often successfully piece together various programs to help uninsured patients, this is rarely a straightforward or transparent process. Farmworkers repeatedly expressed surprise about copays, deductibles, and bills for services they believed were covered. These experiences erode their trust, and in many instances farmworkers opt to avoid U.S. institutions, delaying medical care until they return to Mexico.

Farmworkers also perceive that people with certain insurance plans (e.g., Western Growers, Robert F. Kennedy insurance, and sometimes Medi-Cal) receive poorer service because their plans have low reimbursement rates or are otherwise inadequate. Several providers corroborated this claim, saying that patients with those types of insurance often “get sent to the back of the line.” As a farmworker noted, “The companies buy very cheap insurance policies. They do not pay the doctors.” Another farmworker noted that her husband “has health insurance, but the doctors won’t accept it because it doesn’t pay.”

A small number of programs, such as the Lions and Rotary Clubs fund care for the uninsured. However, the resourcefulness of clinic staffs and their willingness to “go the extra mile” often determine whether patients gain access to such programs. The following account by a nurse at Alisal Health Center illustrates both the kinds of navigational barriers facing farmworkers and the efforts required of clinic staff to help patients gain the benefit of these programs.

We’re currently treating a twenty-seven-year-old woman with bilateral congenital cataracts who’s going to go blind soon if left untreated. She’s picking lettuce and has no place to live. . . . She has no credit, no money, and no immediate family here. She’s now staying in a cousin’s living room with another family. She can’t find her own place because she has no credit references. She can’t speak English, so she can’t call to find a place . . . Medi-Cal won’t pay for her treatment, and the MIA [Medically Indigent Adult program] person was very rude and unhelpful. Luckily, I remembered that the Lions Club provides vision-related assistance and I hooked her up with the Lions Club, who’s going to sponsor her treatment. That woman had absolutely no expectation of being cured and was just waiting to go blind. This is a curable condition, and she was going to go blind because she had no insurance and couldn’t pay for the treatment. It took me about eight or nine hours to make all this happen, which really cut into my other work, but you just have to keep doing it.

The cost of hospital deposits can also be a barrier for indigent patients, even those with insurance, at times with fatal results. This was exemplified by the account of a nurse at Alisal Health Center who explained that, “Some hospitals ask for a deposit, even if the patient has insurance. We had one case where a teen died because his parents did not have \$50 for the deposit and he wasn’t admitted to the hospital.” The lack of payment options at some clinics further discourages access to care, as a farmworker explained.

The consequences of having little money and no health insurance can be debilitating, even deadly.



We need the flexibility of making payments. When we have pain, we simply live with it, because we know that a simple consultation will cost hundreds of dollars, and if we can't pay in full, we'll be in collection.

Many patients are also exasperated by the time and expense of multiple appointments to treat the same condition. A number of informants reported switching from community clinics to private doctors because they believe they receive the same treatment in fewer sessions. Ultimately, they say, it is cheaper to pay a higher fee for one or two visits than to return to the less expensive community clinic many times, especially when income lost from time off is considered.

Lack of Access to Medication and Diagnostic Exams

The significant cost of diagnostic exams and prescription medications further limits farmworkers' access to comprehensive diagnosis and care. Most providers do what they can to work around these limitations, including providing patients with sample medications and applying for pharmaceutical programs that offer free medication for needy individuals. Samples often do not provide for a complete course of treatment, however, and completing pharmaceutical applications is very time-consuming for clinic staff.

A less surmountable barrier is the high cost of diagnostic tests. Some providers admitted to "cutting corners" by avoiding expensive lab tests and diagnosing uninsured patients with more "empirical" methods. For example, one provider noted that she often prescribes broad-spectrum antibiotics for uninsured patients, whereas she would normally conduct a lab test to determine the most appropriate course of treatment.

Difficult Access to Follow-up Care

Both farmworkers and providers report limited access to follow-up care. Not surprisingly, cost is a primary factor for many.

I was supposed to go back for a follow-up checkup, but I never went because I was going to have to pay. Medi-Cal wouldn't pay for that last appointment. I don't know how much they were going to charge me, but it didn't matter because I didn't have the money. I had stitches but the incision wasn't very big, so I wasn't too worried.

Shared housing and telephones can impede follow-up care, making it difficult to communicate directly with patients.

We have problems scheduling follow-up appointments because there are multiple families with one phone, and people are often very bad about leaving messages. Sometimes people don't even have a phone.

Some providers, like the following physician, reported that farmworkers sometimes do not return for follow-up appointments because they see no reason for them once the initial treatment makes them feel better.

Most times, they'll receive the medication and won't come back for another two or three months. I think they're in denial of their problem. If they don't feel bad,

Though Medi-Cal coverage opens some doors to health care, its limits can prevent farmworkers and their families from receiving comprehensive, uninterrupted treatment.

there's no problem. So you try to explain to them that they won't feel bad right away. But then, when it's out of control and they're starting to feel unwell, they come in again, expecting to be seen right away.

A school nurse noted that, while farmworker parents are good about getting their children immunized initially, some do not understand the need to follow up with boosters. She explained that as a result “kids are getting preventable diseases—for example, smallpox has been going up lately.”

Bureaucratic Hurdles

Farmworkers who are eligible for Medi-Cal and other forms of public assistance must overcome numerous hurdles to access those benefits. One of the main obstacles is filling out the many required forms, a particularly daunting task for people with poor English skills and limited literacy. Virtually all Salinas Valley clinics serving farmworkers provide an onsite eligibility worker who fits farmworkers into the patchwork of health care programs serving low-income populations. However, eligibility workers have differing degrees of experience and savvy in this regard, and most are stretched thin. As a result, they generally do not have time to “walk” farmworkers through the application process, a step that is often necessary for approval, as a local eligibility worker explained.

I am more flexible than some other workers. For example, I give people more chances to provide information and I do a lot of follow-up to get their applications completed. I qualify a lot of people due to sheer diligence. But my caseload is also much lower than the main DSS [Department of Social Services] office, so I have more time to follow up with patients.

Some farmworkers believe that clinic workers do not always tell them about programs for which they may be eligible because they do not want to or cannot take the time to help them fill out the paperwork.

Applications also require numerous forms of documentation. Monterey County's Medi-Cal Eligibility Checklist, for example, lists thirty-three potentially required documents. One of the most commonly required items is proof of residency, such as a lease, rental agreement, or utility bill in the person's name. Unfortunately, many farmworkers do not have those documents because they share housing and are not on the lease, nor do they receive any bills in their name. Landlords are purportedly reluctant to vouch for people's residency because they are concerned about violating housing ordinances by renting to too many people per unit. Most farmworkers also do not bring birth certificates with them from Mexico, another Medi-Cal requirement. Perhaps the greatest bureaucratic barrier to coverage is that Medi-Cal recipients must repeat this daunting process quarterly to maintain their benefits.

The county's Medically Indigent Adult (MIA) program, which is intended to cover all indigent individuals in the county, including undocumented immigrants, also has been

Eligibility workers who are given enough time and flexibility to help farmworker families complete Medi-Cal applications can effectively enroll people who otherwise would go without coverage.



A frustrating limitation of many primary care clinics is their weekday-only hours, which force farmworkers to miss work and wages in order to receive medical attention.

criticized as bureaucratic and difficult to apply for. A nurse at a community clinic described the difficulties.

The MIA program needs to be redone. It's cumbersome, and the staff are rude, disrespectful, and inefficient. They treat people very poorly and take advantage of the *campesinos'* humility. You need to be pretty sophisticated to maneuver the MIA system; it's a difficult system even for people born here. They make it very difficult to qualify and will send collection letters in Spanish to people that don't qualify but have racked up bills in the meantime, which are very scary for farmworkers.

Limited Clinic Hours

With few exceptions, clinics and private providers operate only during normal business hours, so farmworkers must take time off work to seek treatment. However, most farmworkers are not paid for sick days or time off for doctor visits, and some risk losing their jobs if they miss too many days when, for example, multiple appointments are required. These economic impacts present major barriers to seeking medical attention and to staying home to recuperate when ill. A farmworker provided the following analysis.

What you need to do to improve the health of farmworkers is pay them for sick days. Farmworkers are sick because they don't stop working even when they are sick. They know that if they don't show up for work their jobs will be taken from them.

Fear of Applying for Public Entitlements

Undocumented farmworkers, particularly recent arrivals, are often fearful of applying for public benefits. Many fear deportation by the INS. At the same time, there is a widespread lack of awareness among farmworkers—and even among many providers—regarding which benefits are “public charge,” with adverse impacts on immigration status.³⁵ According to a clinic director,

We need to teach people to differentiate between accessing services that may jeopardize their immigration status and those that won't. Accessing medical services won't, while some forms of public assistance that make them a “public charge” will.

Transportation

The Salinas Valley region's geography exerts an influence on access to health care because most of the county's services, the county's medical program for indigent adults,

³⁵ According to the Center on Budget and Policy Priorities, “immigrants can accept Medicaid, food stamps, WIC, housing benefits, child care subsidies or other noncash benefits without endangering their immigration status. In addition, although receipt of certain types of cash assistance remains relevant to a public charge determination under the guidance, the vast majority of immigrants have no reason to avoid cash assistance because of concerns about adverse immigration consequences related to public charge. With a few rare, albeit important, exceptions, immigrants who remain eligible for cash assistance under either the Temporary Assistance for Needy Families (TANF) program or the Supplemental Security Income (SSI) program can freely accept that assistance without endangering their immigration status.” From Fremstad, *The INS Public Charge Guidance: What Does it Mean For Immigrants Who Need Public Assistance?*



and most forms of specialty care are concentrated in the city of Salinas in northern Monterey County. Bus service between Salinas and King City was established within the last year, representing a major improvement for farmworkers and other low-income residents. Still, service is limited; there are just five buses a day and the last one leaves Salinas at 5:35 p.m. One provider noted that out-of-towners must sometimes sleep at the hospital if they miss the last bus home.

There is also no public transit from outlying towns and labor camps to hub transportation cities along the Highway 101 corridor. Many farmworkers subsequently rely on private transportation for travel to work, shopping, and health care and other services. People who do not have cars of their own must pay others for transportation, which can be prohibitively expensive. For example, the twenty-seven mile round-trip ride from Soledad to Salinas can cost up to \$40 by way of an acquaintance and as much as \$70 by taxi.

Transportation within Salinas can be daunting as well. Some clinic staff members go out of their way to ensure that patients make it to their appointments. A provider explained that, “We’re not supposed to, but we often give patients cab fare or even drive them to the hospital to make sure they’re getting the follow-up care they need.”

Linguistic and Cultural Competency

Language is a pervasive barrier at every level of health care access, from the otherwise simple task of making an appointment to communication of complex medical information. Numerous providers can be involved in treating a single condition—receptionists, providers, assistants, lab technicians, specialists, pharmacists—all potentially unintelligible. Many primary health care providers in the Salinas Valley speak fluent Spanish, but there are few bilingual dental and mental health providers. Very few specialists speak Spanish.

Even when receptionists at clinics and offices serving farmworkers speak Spanish, language is only half the battle, as the director of the Children’s Oral Health Program explained.

We also help people make appointments, because that’s not always an easy thing for families coming from Mexico. Even if the receptionist speaks Spanish, she’s blurting out “What’s your Medi-Cal number? What’s this? What’s that?” Chances are that if that first encounter is not successful, the mother is not going to call back again. Add that to a sixteen-year-old pregnant child; ask her to do that. In these kinds of cases, we try to have a three-way conference call to connect the parent with the office. That way we help parents gain the skills to make those calls on their own.

Given the limited funds available for trained and qualified medical interpreters, providers often seek assistance from clinic staff or family members. In addition to privacy concerns, however, a recent study in neighboring Santa Cruz County identified numerous errors associated with the use of unqualified medical interpreters.

Serious medical errors can result when providers rely on patients’ relatives and family members to interpret their instructions to patients who do not understand English.



There was an average of thirty-one errors per visit for Spanish-speaking patients using interpreters at pediatric clinics. Errors were most common when ad hoc interpreters such as family members or untrained bilingual nurses were involved. Almost two-thirds of the errors had clinical consequences. Those included wrong instructions on dose and duration of prescribed drugs and omission of important information about patient drug allergies or medical history.³⁶

Language barriers for indigenous-language speakers can be nearly insurmountable. There are virtually no providers or professional interpreters who speak indigenous languages such as Triqui, Mixteco, and Zapoteco. In addition to difficulties with direct communication, the language barriers prevent people from benefitting from Spanish-language outreach and educational materials.

Cultural competence on the part of providers is as important as linguistic competency. Providers need to be sensitive to a range of cultural issues connected with health care and understand and respect ethnospecific beliefs regarding causes and treatments of disease, particularly among indigenous-language patients. A local provider described some of these cultural issues and how they affect patients' experiences with U.S. health care.

The culture of Mexican immigrants who speak indigenous languages is profoundly different from that of their Spanish-speaking neighbors.

Many Mixtecos are animistic and don't trust the western health care system. They have a different view of health and illness. We see a fair amount of ethnospecific diseases here. *Susto*, *empacho*, and soul-robbing, which is the belief that illnesses in babies are sometimes caused by the soul being robbed. . . . Indigenous women are also very modest and don't like being seen nude, even by female doctors. . . . They say that in Mexico the doctors treat them under a sheet or blanket. We have to explain to them why we don't do that here. There was one case of an Oaxacan woman who said she didn't want to be seen during birth, but because she didn't speak Spanish, she couldn't explain that when she arrived at the hospital. She was surrounded by eleven interns during the birth, and, as you can imagine, was extremely upset.

A provider noted that the staff at her clinic tries to be culturally sensitive but still makes mistakes.

The staff here is very sensitive to cultural issues. All staff members are bilingual, and there's an upcoming conference on indigenous health that we'll be attending. It would be good to have cultural sensitivity training for all providers. There's currently no formal training, and people learn these things on the job. But in the meantime, they can make mistakes and offend patients, who may not come back. But there's also a fair amount of forgiveness on the part of the patients—"those guys are just dumb *gabachos* [white people]."

Education must also be extended to help people comply with medication and other regimens when they do obtain treatment. Limited literacy and language skills, cultural factors, and some mistrust of western medicine and providers affect compliance with treatments, as a provider explained.

People don't understand dosages well. For example, a female patient told me of taking Paxil, saying "I take it whenever I need it." She didn't understand that she needed to take it every day. We could tell her that, but she would need to

³⁶ Harlick, Health Care for Spanish Speakers Lags Due to Slips of the Tongue.



talk to her *comadre* to make sure it's really okay to take it every day. . . . Parents are also very resistant to giving their children drugs. They're afraid they'll become *drogados* [drugged] or *entumidos* [numb]. They prefer natural remedies or remedies that look like Mexican drugs. For example, they might take something if it looked like *Mejoral* (a Mexican cold medicine).

Treatment at Clinics

In addition to other barriers, a number of farmworkers have complained of discrimination and poor treatment by clinic staff.

I went to the clinic so that they could remove a molar. They treated me badly. They treat you as if you were an animal. They didn't explain anything; they just removed the molar. When they took my molar out, they were very rough. It was as if they were taking a part out of a car. They were pulling with all their might. They didn't give me any pills for the pain. I took my own medicine for my toothache.

At the clinic they didn't pay any attention to my friend. The Anglos and those that speak English are seen very quickly. Everyone should be treated well, regardless of what language they speak and whether or not they have health insurance.

The ladies [clinic staff] won't tell you about those programs [that pay for certain types of medical care]. I heard about the program from a friend. They told her about it because she speaks English. Most of the women I know who take their children there haven't heard about the program. I think it's because we only speak Spanish.

Given limited clinic hours, farmworkers often cannot take time to shower and change before going to clinics from work. Some are too ashamed to go to the clinic in their work clothes and thus forego treatment; others report rude behavior from clinic staff because of their appearance.

There's a lot of discrimination against fieldworkers, sometimes simply because we come into the clinic straight from the fields and we're a bit dirty. As soon as we come through the doors, you hear the nurses complaining about how we're going to dirty the carpets.

Despite complaints, many farmworkers are happy with the care they receive, noting that health care providers are competent and respectful. Patient satisfaction is often associated with the presence of Spanish-speaking staff or Spanish-language interpreters, as witnessed in the following comments.

I was happy with the way I was treated at the hospital. They had translators there. The doctor didn't speak Spanish but there were nurses who did. The people there at the hospital helped me fill out the paperwork. It wasn't difficult to understand.

They talk Spanish at these clinics and so we have faith in them. They take care of us, give us medicine, cure us, and have experience.

Dissatisfaction with care, however, imposes a barrier between the system and some farmworkers, who may not continue to seek treatment. The U.S. health care environment

Farmworkers and their families often feel that they receive second class treatment from health care providers and administrative staff.



is generally very different from the Mexican systems many farmworkers are familiar with. This disparity can lead to frustration, as demonstrated in the following farmworker accounts.

I would like to have a particular doctor that always would see me instead of seeing a different doctor each time I go to the clinic. You lose a lot of patient history like that, because by the time the new doctor reads your previous history and then another doctor reads the newest history, you look like a big blur. They don't take enough time to read your medical history and you lose trust in the doctors.

In Mexico, the doctor checks out your entire body at each consultation. He touches you and asks if it hurts here or there. They literally put their hands on you to feel you and make a better-informed diagnosis. Here, it's like the doctor is afraid to get near you.

Here, they never find anything wrong with the patient and they never cure you of anything. Here, it's all about Tylenol; everything is fixed with Tylenol. In Mexico, all the doctors are great. Here, they don't take the time or maybe it's because they're afraid of being sued. In Mexico there's no such thing as suing the doctor, so I guess they feel more comfortable giving you a shot and having you go on your way.

Without exception, farmworkers complain about the long periods spent waiting for medical attention at public and nonprofit clinics.

Conversely, some farmworkers feel that medical care is better in the U.S. As one farmworker claimed, "Medical care is better here than in Mexico, because although there is a long wait, my little girl gets seen by a doctor and is taken care of. In Mexico, the doctors just inject you and that's it."

Perhaps the most common complaint among farmworkers is long waits at clinics. One working mother described a typical day.

The wait [at the clinic] is horrible. It's not worth it. . . . I'll try to plan the entire day around my appointments because I have to ask my job for permission to miss the day. Since my job won't allow me to miss work for part of a day, I have to take an entire day off, rather than a couple of hours. Once I've planned my day, packed my breakfast and lunch, and gotten to my first appointment, there are a million people there. . . . The doctor takes longer in the examining room. I'm now going to be late to the child's appointment. I finally get out and run to the child's appointment. It's late so they put me on the back burner until the nurse has time to take my information down. Finally, I'm seen at noon. Now, I don't leave the child's appointment until 2 p.m. and have missed the WIC appointment. And at WIC, they don't play. If you miss your appointment, you miss out and are rescheduled for the next time. . . . Why even make an appointment if the . . . nurses and doctors don't stick by them?

Ultimately, a physician notes that patient satisfaction is largely a function of provider respect for patients.

The most important aspect of being a good provider and being culturally competent is to treat patients with respect. The number one issue I tell my staff is to treat all patients with concern, caring, compassion. When patients feel they are treated with dignity, they will come see you. Our patients have dignity. They work hard and I respect them. They know this. That is why they come.

Challenges Faced by Health Promotion Programs

There are several health promoter programs in the Salinas Valley, representing a promising strategy for providing farmworkers with health and social service education and information. While these programs have met with a high degree of success so far, they also face challenges. Many programs do not have funds by which to compensate their *promotoras*, making it difficult to retain people and maintain good morale. These organizations try to offer non-cash incentives such as jackets, badges, and retreats and are looking at the possibility of establishing some form of accreditation that could help people ultimately obtain paying jobs in health care. Supervision is also challenging, since health promoters often work on their own in the community, as the mayor of Salinas pointed out.

Promotoras require constant training and supervision. They need to know what they know and what they don't know, what to teach and when to refer to specialists. Much of the outreach is basic and can be handled by the *promotoras*, but they have to be careful not to give the wrong advice about problems that require specialists. The resources to do trainings are crucial.

A further challenge is the inability of clinics to schedule timely appointments for farmworkers referred by health promoters, which can undermine the credibility of their efforts.

Barriers that Impede Access to Dental Care

In general, access to dental services is even more limited than access to primary health care. There are very few private dental providers who accept Medi-Cal patients, fewer still who speak Spanish, and none who speak indigenous languages. The few farmworkers who have dental insurance through their jobs often lack full coverage, and the high cost of dental care in the U.S. is often prohibitive for most farmworkers.

I have three molars that I need to get taken care of. A while ago they were going to charge me \$450 or \$500 for a cleaning and to fill one cavity in a molar. My brother went to a dentist. They cleaned his teeth and filled one cavity. The insurance paid half, but he still had to pay \$350.

A lack of appreciation among farmworker families for the importance of dental health care, particularly preventive work, also discourages access to dental care. According to the director of the Children's Oral Health Program, only 29 percent of families currently enrolled in Medi-Cal utilize the dental benefits. She believes that "the issue is awareness more than cost, since there's no copay with Medi-Cal unless it's for something cosmetic." However, she admits that "another part of the problem is that there are very few Medi-Cal dental providers."

Dental care is expensive, even for basic preventive services, and providers who accept Medi-Cal are in short supply in the Salinas Valley.

Barriers Associated with Mental Health Care

Despite a strong need and increasing demand for mental health care among farmworkers, there are few options available. A very small number of mental health providers accept



Medi-Cal, and free or low-cost counseling services for people who lack insurance are rare. According to the county’s Behavioral Health director, “People with Medi-Cal can get treatment, but it is difficult for others, who can only get emergency services.” The director of Behavioral Health is very interested in implementing a single standard of care model in which all county residents, regardless of insurance status, are eligible for mental health services. Mental health services are also restrictive in that they are concentrated in the city of Salinas, leaving the southern part of the county essentially providerless.

With so few mental health providers, existing nonprofits cannot afford to promote their services as they are already overwhelmed by the need, allowing them to address only the most urgent cases.

There is no outreach for mental health services, but the services are already maxed out and there are not enough bilingual staff. So in a way, it would be a problem if more people tried to access those services.

There are counseling and other programs to prevent and reduce stress, but what happens when a person stops doing counseling? A lot of mental health problems are situational. Those root situations need to be addressed in order for there to be some long-term impact of mental health assistance.

Providers note that cultural stigmas among farmworkers around accessing mental health care have also been a significant barrier, particularly among adults.

There’s a big stigma around getting mental health services. When I mentioned that possibility to my mother, who was depressed, she said, “I’m not crazy.” I often refer people to their priest or pastor for mental health counseling. That way no one gets offended.

People think you’re crazy or you’re not crazy. There’s nothing in between. We need to get the word out about redefining mental health services in culturally appropriate ways. For example, by using terms such as *familia sana*—healthy family—instead of mental health.

One provider noted that some people are afraid to be seen entering mental health clinics, suggesting that “it would be good to have mental health providers at regular clinics. A lot of people don’t like coming to mental health clinics because of the stigma.”

Despite these provider perceptions, many farmworkers report that they are open to counseling, especially for their children. In a conversation with members of the farmworker community at a Lideres Campesinas meeting, one participant suggested that mental health counseling is a western concept that is not culturally appropriate for Latinos. However, the other members of that group countered that they were very interested in counseling for their children but were frustrated that their lack of Medi-Cal coverage prevented them from doing so.

Numerous informants commented on the urgent need for culturally and linguistically appropriate mental health care and education materials for the farmworker community. As a provider from Monterey County Children’s Mental Health Services noted,

Salinas Valley informants gave conflicting accounts of how serious the stigma against mental health care is among farmworkers in the region.



Forty-eight percent of the children we serve at Children’s Mental Health are Spanish-speaking, yet we don’t have any Spanish-language videos or literature. Parents are always interested in finding out how they can help their kids, and there would be a lot of interest in reading up and learning about the issues.

Informants also noted a need to help farmworkers identify mental health problems in the first place. A mental health provider explained how a lack of understanding prevents people from receiving needed care.

We need to increase the community’s understanding of what mental health is. Most people don’t think they have mental health problems, even though they may have histories of domestic violence and rape. Those things have never been discussed among adults. They only come out when adults bring their kids in for counseling.

Facilitators to Care

Cultural Brokering and Peer Networks

Despite numerous outreach programs providing farmworkers with information about available health, social service, and other resources, word of mouth remains perhaps the most effective way of transmitting that information. Farmworkers who have been in the Salinas Valley for several years are instrumental in showing more recent arrivals “the ropes.” They provide newcomers with vital information on a broad range of issues, from Medi-Cal eligibility to getting around on public transit. The role of these networks is vital; for example, a number of farmworkers commented that they learned about health care programs for which they were eligible from other farmworkers rather than from clinic staff, who may be too busy to inform all patients of these programs. In addition to friends and family, peer networks and cultural brokers include a broad range of other actors, including *mayordomos*, who can be instrumental in facilitating or impeding access to health care, *raiteros* (who provide farmworkers with rides to and from the fields), *loncheros* (who sell lunch and snacks in the fields), and other providers of goods and services, including hair stylists and grocery store owners.

Health Promoter Networks

There is a high level of awareness among Salinas Valley providers regarding the importance of health outreach and the use health promoter networks as a way of transmitting information to farmworkers. There are several groups in the Salinas Valley currently using a *promotor* model of health outreach, particularly CCA and Lideres Campesinas. Numerous other groups provide health outreach services, and there is strong interest in expanding on these existing programs and models.

Dedicated and Culturally Competent Providers

The Salinas Valley is blessed with a cadre of dedicated and culturally competent health care and social service providers who are committed to improving the health and well-being of farmworkers. The vast majority of providers speaks Spanish and is familiar with

Salinas Valley providers show a relatively high degree of cultural and linguistic competency.



farmworker health-seeking beliefs and practices. Since this is a constant learning process—particularly given the recent and ongoing influx of farmworkers from Oaxaca—providers have made many efforts to further educate themselves on these matters via workshops and speakers on ethnospecific health beliefs and practices. In addition, many providers take extraordinary measures to ensure that their patients receive needed care by providing them with cab fare, driving them to hospitals or clinics, and seeking resources to cover treatment for uninsured patients.

Supportive Growers

There are a number of progressive growers in the Salinas Valley who have made strong efforts to provide farmworkers with reasonable pay, benefits, and good working conditions. Those growers and grower representatives, including the Grower-Shipper Association and the Farm Bureau, are aware of the responsibility of growers in improving farmworker health and well-being and have expressed an interest in contributing to future efforts to do so.

Community-based Research Activities

A number of public and nonprofit entities in the region have invested resources in population-based research, recognizing the importance of data for guiding program development and fundraising. The Monterey County Department of Social Services' Community Action Agency recently commissioned the Farmworker Housing and Health Assessment, which has provided invaluable information about farmworkers in Monterey and Santa Cruz counties. The county Health Department recently completed *Impacto II*, which studied the behavioral risk factors of 1,000 Latinos throughout the county as a follow-up to the *Impacto I* survey completed ten years earlier. Additionally, CCA recently conducted a census of residents in several of its housing complexes to guide the development of its *Promotor de Salud* program.

A number of growers and grower representatives have expressed interest in actively working to improve the health and well-being of Salinas Valley farmworkers.

Summary of Community Assets and Liabilities

Main Assets

Broad awareness of issues affecting farmworker health and well-being

There is a high level of awareness of and broad concern about farmworker health and well-being on the part of virtually all stakeholders, including public and nonprofit health and social service providers, elected officials, labor unions, and many growers. There is agreement on the part of all parties that farmworker health and living conditions must be improved and there is genuine interest in taking action.

Culturally and linguistically competent staff and services

Virtually all major health care providers are familiar with the special needs of farmworkers and an unusually large number of them are linguistically and culturally competent. Many of the valley's health and social service providers are former farmworkers or come from farmworker families. These providers consequently can communicate directly and effectively with clients. In addition to improving service, cultural and linguistic proficiency among providers reduces medical errors and eliminates breaches of confidentiality. Ultimately, it makes for more satisfied patients, who are more likely to return for care and refer others as well.

Dedicated staff

The Salinas Valley is blessed with many dedicated and committed staff members who do not hesitate to go out of their way to ensure that patients obtain needed services.

Health outreach and promoter networks

There is a high level of awareness among providers regarding the importance of health outreach and the use of *promotora* networks as a way of transmitting health-related messages to farmworkers. Several groups in the Salinas Valley already employ the *promotora* outreach model, and there is strong interest among providers in expanding its use. There is also a contingent of current and former farmworkers in the valley. These longtime residents informally show newcomers the ropes in terms of accessing services and navigating health and social service systems.



Main Liabilities

Lack of comprehensive health insurance

The lack of comprehensive health insurance is a major barrier to improved health care for farmworkers. Many uninsured and underinsured farmworkers avoid seeking medical and dental attention because of the expense of deductibles, medications, and diagnostic services. As a result, illnesses go unchecked until they become expensive emergency conditions.

Lack of services in southern Monterey County

The severe concentration of health and social services in Salinas makes it difficult and expensive for residents of southern parts of the county to gain access, particularly for specialty care.

Lack of culturally and linguistically competent providers

Despite the large number of Latino and Spanish-speaking providers in the Salinas Valley, gaps remain in the region's supply of culturally and linguistically competent services for farmworkers. The gaps are most severe among dental and mental health providers, few of whom speak Spanish. Speakers of indigenous languages are the most affected. The lack of cultural competence among some providers is an additional barrier to the provision of quality care for farmworkers; most providers gain cultural competence on the job and inevitably make mistakes that can drive away patients.

Inadequate mental health services

Many farmworkers suffer from high levels of stress, anxiety, and depression, placing them at risk for problems that include substance abuse and domestic violence. Mental health services in Monterey County are quite limited. County-run programs only accept patients with Medi-Cal, while virtually no private providers accept patients lacking private insurance. A small number of community-based organizations, including Catholic Charities, the Women's Crisis Center, and several substance abuse and youth programs, offer counseling services. The majority of farmworkers, however, must turn to religious leaders for counseling or do without.

High cost of housing

Salinas is currently one of the most expensive housing markets in the U.S. Many farmworkers live in overcrowded conditions, and many more live in substandard housing, including garages, tool sheds, tents, and even caves. The disparity between housing costs and local incomes presents a formidable barrier to efforts to recruit and retain qualified providers.

Menu of Community-based Options

Improving farmworker health and well-being and access to quality health care will require a multi-pronged approach that stimulates collaboration among all stakeholders, including farmworkers, growers, and the public, nonprofit, and foundation sectors.

Improved Access to Primary Health Care and Outreach

- Provide support for improved public transportation from labor camps and other areas not served by public transit to Salinas and other towns with primary care facilities.
- Educate health care providers about supplementary programs sponsored by organizations like the Lions and Rotary Clubs, which can provide assistance with extraordinary expenses not covered by insurance.
- Continue and expand support for health promotion activities, including *promotor de salud* programs, community-based screenings, mobile health vans, nutrition education, and outreach regarding existing programs and services.
- Support case management programs to ensure that high-risk patients identified through health promotion activities obtain access to needed care.
- Support increased outreach and education regarding domestic violence, including what constitutes domestic violence, victim's rights in the U.S., and where to go for needed services.
- Support new and innovative forms of health outreach, such as video monitors on farmworker labor buses and at other locations frequented by farmworkers.

Increased Access to Health Insurance

- Support efforts to increase farmworker access to health insurance via innovative public/private partnerships between funders, growers, public entities, nonprofits, and farmworkers.
- Support efforts to increase the number of eligible farmworkers accessing entitlements such as Medi-Cal and Healthy Families by increasing funding for eligibility workers and facilitating access to required documentation such as proof of residency and birth certificates.
- Support efforts to educate farmworkers and providers regarding “public charge” provisions in order to increase the number of people accessing benefits to which they are entitled.
- Support increased funding for additional clinic staff to enroll patients in free pharmaceutical programs.

Housing

- Increase support for programs such as the Housing Opportunity Center to help farmworkers become creditworthy and take advantage of affordable housing programs.
- Increase support for rental assistance programs to help farmworkers facing temporary financial crises.



- Increase support for tenants' rights advocacy groups to negotiate with landlords for needed repairs and improvements.
- Support advocacy for "just cause" eviction laws so tenants can request repairs and obtain proof of residency from landlords without fear of eviction.

Mental Health

- Provide support for increased farmworker access to free and low-cost mental health and substance abuse counseling services, particularly for those with no insurance.
- Support parenting classes, counseling programs, and support groups for parents and children dealing with family conflicts.
- Provide support for non-counseling options for increasing coping skills and other ways to improve mental health, including recreational activities, workshops, informal support groups, and co-counseling, and provide lay people with counseling training so they can serve as mental health promoters within their communities.
- Increase support for youth programs, including gang violence prevention programs, recreational activities, and mentoring and tutoring programs.
- Provide assistance, support, and mental health training to members of the non-medical community, including church leaders, who already provide important counseling services to the farmworker community.

Occupational Health and Safety

- Support increased outreach and education for farmworkers regarding identifying and reporting occupational health and safety hazards, growers' responsibilities with respect to occupational health and safety, and their right to designate a doctor for Workers Compensation reviews.

Cultural and Linguistic Competency

- Support efforts to increase the number of Latino and indigenous-language health care providers via mechanisms that attract and retain bilingual and bicultural staff, provide advanced medical training for health promoters, and encourage more Latino students to enter health care fields.
- Support increased efforts to provide cultural and linguistic competency training for health care providers, particularly those serving indigenous-language-speaking patients. Ideally, such training would take place before providers begin seeing patients.
- Support mechanisms to improve access to professional medical interpreters, including arranging funding to hire more professional interpreters, supporting and encouraging Spanish and indigenous-language speakers to be trained as interpreters, encouraging collaborative efforts with linguistic institutes in Monterey, California, to increase the supply of interpreters, supporting policy efforts to expedite legal residency for undocumented residents with interpreter skills, and encouraging AT&T and other medical translation services to offer indigenous-language services.

Appendix

Methods Used for Salinas Valley

Community-based Content

The report summarizes opinions and facts given by communities of farmworkers, of people in charge of delivering services to farmworkers, and of other observers concerned with farmworker problems. The purpose is to describe the community through its own eyes. These recommendations and observations reflect a consensus in the community as mediated by the researchers.

Methodological Steps

The approach of this 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 survey was conducted in September of 2001. It allowed identification of the main Salinas Valley neighborhoods where farmworkers live and descriptions in some detail of the main programs that provide services to them. The telephone inquiry, which involved conversations with nearly twenty people, did not allow for an understanding of the strengths and weaknesses of the service resources available to farmworkers. And, of course, it did not allow for input from farmworkers identifying their major health concerns and describing the primary barriers they face in obtaining services.

The research team implemented one protocol for farmworkers and another for providers and others in the community. Four interviewers—Ron Stochlic, Nancy Mullenax, Mireya Samaniego, and Xochitl Villaseñor—carried out a total of ninety-seven interviews under the guidance of Rick Mines in September, October, and November of 2002. Forty-four interviews were conducted with farmworkers, while fifty-three were with health and social services providers and other informants, such as outreach workers, educators, community organizers, elected officials, and grower representatives. Members of the research team also attended a series of workshops, conferences, community meetings, and similar events during this field work.

The sampling process endeavored to capture major networks of individuals. This proved difficult given the expansive geographic area that makes up the Salinas Valley region and the effort to include farmworker informants in each Salinas Valley town. As a result, the sampling of individual farmworkers focused less on network sampling and more on ob-



taining interviews with a representative sample, ensuring geographic representivity. Also, the sample intentionally included people of different ages, men and women, and people separated from and with their families. Three of the farmworkers interviewed were indigenous-language speakers—two Mixteco-speakers from Oaxaca and one Tarascan-speaker from Michoacan.

Interviewers intentionally followed up on issues that the community (from all sectors) identified as crucial to farmworker health. In addition, they were careful to sample all types of health care providers, such as physicians, physician assistants, nurses, medical assistants, mental health professionals, intake workers, administrators, and patient care associates. The interviewers were successful in obtaining interviews with individuals in each of the organizations considered to be front line groups delivering services to farmworkers.

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 may not be edited 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 revised the codes used for previous community-based studies to make them more relevant to the Salinas Valley. This helped in systematic analysis of field notes (by means of Atlas software). 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.

The AWHS team held a two-day training program for the field work staff before returning to the field. 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 = 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. 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.

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