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Inequality and health among foreign-born latinos in rural borderland communities

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ABSTRACT

Thousands of Mexicans and Central Americans settle in communities along the borderlands between Mexico and the United States. Many live and work in rural communities characterized by poverty and limited access to basic resources. Drawing on qualitative research, this article reports on inequalities and health among foreign-born Latinos in rural borderland communities. From 2015 to 2016, the study team conducted research in Inland Southern California's Eastern Coachella Valley with Mexican farmworkers, farmworker advocates, community leaders, healthcare service providers, and local political leaders. The analysis of field notes and interviews demonstrates how situational and temporal factors position this foreign-born population as vulnerable to inequalities across multiple social systems resulting in low social status, lack of employment and housing stability, and limited access to healthcare services. Over time, the experience of both situational life events and persistent and daily chronic strain infringes on self-concept, including mastery or control over life and self-worth, and contributes to stress and subsequent poor mental health outcomes (e.g., depression). The research calls for local community action, healthcare policy change, and further in-depth research on structural inequalities in health among foreign-born Latinos.

1. Introduction

Each year, thousands of Central Americans cross into Mexico, the southernmost country in North America, and some of those already in Mexico join the thousands of Mexicans who cross the US-Mexico border (Krogstad, 2016; Mahler and Ugrina, 2006). Based on 2016 estimates, of the 43.7 million foreign-born population in the US, 26% are from Mexico and 8% are from Central America, mostly from the Northern Triangle countries of Guatemala, El Salvador, and Honduras (Lesser and Batalova, 2017; Migration Policy Institute, 2016). While some enter the US legally (e.g., temporary workers, green card holders), many enter as undocumented foreigners and live and work in rural or semi-rural communities within the border states of Arizona, California, New Mexico, and Texas. These communities, often referred to as *colonias* in Texas and New Mexico and unincorporated areas in California, are characterized by substandard housing, poor infrastructure, unsanitary conditions, and unsafe public drinking water (Hernandez, 2018; Pan American Health Organization & World Health Organization, 2012).

Latin American immigration is changing the landscape of rural

America (Lichter, 2012). The Housing Assistance Council (HAC) estimates approximately 6 million Latinos live in rural areas of the US (HAC, 2012), an increase of 4 million from a decade prior. The majority, concentrated in border states, work in low-wage jobs, most often in agro-business, construction, or the service industry (HAC, 2012). While many foreign-born Latinos establish cultural, economic, and social roots in American culture and society, their undocumented statuses (e.g., undocumented Mexican) place them in marginalized positions, limiting access to public services such as healthcare and stable employment (Chavez, 2013). This marginality renders this population vulnerable to the inequality stemming from discrimination and exploitation, which can profoundly affect their health and wellbeing (e.g., Horton, 2016; Quesada et al., 2011).

1.1. Inequality and health

Social epidemiologists have repeatedly demonstrated associations between inequality and health, as well as theorized and evidenced how inequality becomes embodied. For instance, in their review of the

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literature on income inequality and health, Pickett and Wilkinson (2015) found substantial evidence across the globe for a causal connection between income inequality and health—the greater the inequality the worse health outcomes. This may be because large income inequality exacerbates class and status differences increasing social distance and negatively affecting health and wellbeing. Inequalities across life experiences such as abuse, food insecurity, and economic and social disadvantage “leave their marks on the body” (Krieger, 2005, p. 350). The social world becomes part of our bodily existence. Over time, socially inflicted inequality, including racial, class, and gender-based discrimination gets under the skin; it becomes embodied transforming bodily characteristics and biological processes (Krieger, 2001). The embodiment of inequality may trigger neurobiological changes involving metabolic and physiological responses to stress such as increased blood pressure, cholesterol levels, hypertension, and adipose tissue (Brunner, 1997, 2007; Dressler and Bindon, 1997).

To better understand the relationships between inequality and health, we build on trends in the anthropological and sociological study of migration and health to highlight how positionality places foreign-born Latinos in structurally vulnerable positions and compromises their mental and physical health (e.g., Holmes, 2011, 2013a; Organista et al., 2013). We use the term positionality to refer to foreign-born Latinos' social position and location within a hierarchical social order and complex web of power relations (Quesada et al., 2011). We also consider the impact of life event and chronic daily stress on health outcomes. We drawing on Pearlin and colleagues (1981; Pearlin, 1999) Stress Process Model to explain the connections between low social status and high levels of psychological distress. Thus, we consider life events such as migration as a factor that can reframe foreign-born Latino's experiences of persistent and daily chronic strain (e.g., social role or financial strain). In this framework, what was once perceived as manageable becomes unmanageable and leads to negative changes in roles and experiences. When such strain becomes bothersome, it can infringe upon individual self-concept raising questions about one's sense of mastery (i.e., control) over life events and calling into question one's self-esteem or self-worth. This experience creates stress and can explain poor mental health outcomes such as depression.

In this article, we focus on how shifting experiences of citizenship, ethnicity, and geography, play out in everyday life experiences calling into question mastery over life and self-worth. Both structural vulnerability and the Stress Process Model are helpful to examine how foreign-born Latinos experience inequalities in health when their position within social institutions constrains their ability to live well, or to be and do what is generally agreed upon and understood as important to wellbeing (Dressler, 2012). Not being able to achieve life goals collectively defined as important can be a profoundly stressful experience and lead to psychological distress, psychosomatic symptoms, and compromised immune system (Dressler et al., 2016; Read-Wahidi and DeCaro, 2017; Tallman, 2016).

Our analysis focuses on the multiple environmental contexts within which inequalities arise, which provides structure to examine how inequalities embedded in the macrosystem, including socio-cultural, political, and economic factors, as well as exosystem such as law enforcement and infrastructure intersect with family and social networks at the microsystem to shape individual-level health outcomes (Dahlberg and Krug, 2002). Foreign-born Latinos may experience inequality at multiple levels: institutionalized racism at the macrosystem, lack of community resources at the exosystem, and microaggressions at the microsystem (BonillaSilva, 1997; Gee, 2002; Williams, 1999). These multilayered inequalities contribute to historical (e.g., colonialism) and situational (e.g., migration and social policy change) (Bourgois and Hart, 2011) forms of what Galtung (1969) referred to as structural violence. This term refers to the inequalities embedded in social structures or institutions that prevent individuals from meeting their basic needs. The violence itself is often invisible; however, it becomes part of the fabric of our social worlds and dictates, in seemingly

ordinary ways, access to resources, education, and power (Farmer et al., 2006).

2. Methods

2.1. Study setting

Our study focused on the life conditions of farm workers in rural communities in Inland Southern California. From 2015 to 2016 we conducted research in the Eastern Coachella Valley (ECV) located in the 45-mile long Coachella Valley. The ECV is one of the richest agricultural areas in the world, contributing as much as \$600 million in annual agricultural production (Coachella Valley Economic Partnership, 2014). It is also one of the most impoverished areas of California, known for its undocumented and underinsured immigrant population living in poverty and working in the fields (London et al., 2013; Marcelli and Pastor, 2015).

The eastern Coachella Valley sits on the outskirts of the valley and is home to Coachella, a city of just over 40,000 residents, and four unincorporated communities—Mecca, North Shore, Oasis, and Thermal—that do not have their own government structure. These unincorporated desert communities, which appear to be engulfed by agricultural lands, lie on the northern shore of the Salton Sea, an area once full of booming resort towns. Over the years, the Sea's increasing salinity and pollution from agricultural runoff contributed to the decline of the tourist industry. Abandoned buildings, the stench of decaying fish, which on windy days travels across the valley, and trailer parks now characterize the landscape.

There is a long and complex history of the exploitation of farm labor in the eastern valley (DuVry, 2007). This exploitation began with the Spanish and Californian colonists' subjugation of Native American and Indigenous Mexicans through the mission system, which established an underclass forced to work the land and convert to Christianity. While the secularization of the mission system in the late 1800s upended forced labor, the racist attitudes of the post-Mexican-American War era continued to subjugate Mexicans (Gómez, 2008). By the end of the 19th century, Euro-Americans from the eastern US and European settlers bought up the large mission ranchos and landholdings and converted them to farm lands, developing agro-business (Pitt, 1998). By the turn of the 20th century, persons of Mexican origin in the valley, many of whom had worked the land as forced laborers and developed the local infrastructure as railroad laborers, had little to no economic, social, or political power. The introduction of the US immigration Bracero program, a policy designed to provide easy access to low-cost, temporary, non-citizen migrant labor from Mexico, further subjugated resident Mexicans in the valley (Cardenas, 1975; Cohen, 2011). Today, this region is home to predominantly Mexican-origin farm working families living in poverty.

2.2. Approach

In this research, we used a community-based participatory research (CBPR) approach to successfully engage the community and conduct meaningful research. The very concept of research creates distance between communities and academics. Underserved communities may perceive research as exploitative, which can exacerbate power differentials (Wells and Jones, 2009.) CBPR, as a methodological approach, considers contexts (e.g., historical, socio-cultural, economic, political) and engages community members as partners in the research process; it also pays particular attention to trust development, community capacity or readiness to engage in research, co-learning, and power differentials (Belone et al., 2016). By using CBPR, we sought to develop rapport and long-term partnerships with leaders and farmworkers in the ECV to engage them in identifying research priorities important and meaningful to their community. While this research was exploratory, the lead investigator had expertise in mental health and substance use

services research and conversations often focused on substance use related health disparities such as alcohol abuse among male farmworkers (Arcury et al., 2016; Duke and Gomez Carpinheiro, 2009).

Throughout the research, community provided input on research questions and study design, collaborated on study recruitment, helped analyze and interpret data, and facilitated and/or led local study dissemination efforts (Minkler and Wallerstein, 2008). Our approach provided an opportunity to develop collaborations with community leaders and research participants in a geographic area and population that our university's medical school had not previously engaged in research. One of the primary missions of our medical school, established in 2013 as a community based school, is to serve Inland Southern California by training a diverse physician workforce and developing innovative research (Olds and Barton, 2015). However, the eastern valley, only 85 miles or a 1.5-h drive from the university, is rural. In the US, rural health is an often-overlooked health disparity (Gilbert et al., 2018).

2.3. Data collection

Prior to the start of data collection, we obtained ethical approval for the study from the University of California Riverside's Institutional Review Board. In an effort to build trust, understand community capacity to engage in research, and identify meaningful research topics, we first conducted informal and unstructured interviews with diverse stakeholders in the Coachella Valley. We worked through existing contacts in the valley who connected us to community leaders, advocacy groups, farmworkers, members of farm working families, political officials, and healthcare providers. These interviews, which took place throughout the Coachella Valley in city halls, community organizations, healthcare service organizations, restaurants, and a trailer park, also offered opportunities to observe the context and everyday life in the valley (Bernard, 2002). Through observations, we obtained a deeper understanding of the geographic layout of the Coachella Valley (e.g., the eastern versus the western valley), community and public resources, civic opportunities, and locations of hidden communities such as undocumented foreign-born Latinos and indigenous Mexicans. We noted and jotted down in notebooks key conversation points and observations and entered them into a Word document after each interview (Emerson et al., 1995).

Through these interviews, we learned that alcohol abuse among male farmworkers was a community concern. To better understand how best to design meaningful research on this topic, we held a Community Review Board (CRB), a one-time group interview designed to obtain input on research (Vanderbilt University Medical Center, 2016). Nine community members, including: one male farm worker, two farmworker advocates, two students, one youth organizer, and three service providers attended the CRB. All participants were Mexican or Mexican-heritage and either grew up in the ECV in a farm working family and/or served the local farm working communities. At the beginning of the CRB, we provided background information on substance use and related risks (e.g., sexual and HIV risk) among Latinos, focusing on Latino male farmworkers' health behaviors, and elicited participants' perspectives on this topic and its importance to local farm working communities. A directed conversation on research questions, sample and recruitment strategies, participant remuneration, and cultural and ethical considerations followed the group interview.

During the CRB, participants suggested we conduct focus groups with both men and women living in farm working communities as well as have a male researcher conduct interviews with men. They also suggested the interview guide transition from general topics (e.g., what's a typical day like for farmworkers) to community health concerns to sensitive and potentially uncomfortable health topics, including alcohol and drug use and related risk behaviors (e.g., sexual relationships, HIV risk). Consequently, in the subsequent step of the research we held focus groups with farmworkers, farmworker

advocates, and members of farm working families in the ECV.

Participants had to be 18 years or older, self-identify as Latino/a, live in the eastern valley, and be a current or former farm worker or have grown up in a farm working family. We collaborated with the local chapter of a farmworker advocacy group and a church to recruit women, and a farm worker in a managerial position to recruit men. We conducted one focus group with exclusively men and two with women. A male researcher conducted the all-male focus group and female researchers conducted the all-female focus groups. Because our research was exploratory and sought to build trust, understand community capacity to engage in research, and identify meaningful health research topics, we stopped data collection once these objectives were achieved.

We began each focus group by eliciting general information on the day-to-day life of farm workers in the ECV, their common struggles (e.g., financial or family problems), and community health concerns; and then asked specific questions about substance use and related risk behaviors. Focus groups were about 85 min, audio recorded, and professionally transcribed. Participants were remunerated for their time and reimbursed for travel expenses. Quotes were translated from Spanish to English by a bilingual speaker.

All focus group participants identified themselves as Mexican (100%) and all but one was foreign-born. Participants on average were 43 years of age. Most were women (92%), had children (88%), were married or in a long-term partnership (56%), and lived in local trailer parks. The majority (56%) were monolingual Spanish speakers, 36% were bilingual Spanish and English, and 8% were bilingual Spanish and Purépecha (an indigenous group from the Mexican state of Michoacán). More than two-thirds (68%) of participants did not complete a high school education. The majority (72%) had a job, 12% were unemployed, 4% were retired, 4% a student, and 8% declined to report employment status. Of those employed, over half (52%) worked in the fields. Those not working in the field cited self-employment such as childcare or selling food as their source of income. Nearly half (44%) had no health insurance, and 40% had not seen a provider in the past year.

The study sample's socio-demographic characteristics are similar to recent population profiles of the eastern valley. In their fact sheet, *Unauthorized and Underinsured*, Marcelli and Pastor (2015) estimate that of the more than 34,000 people in the eastern valley, 42% are immigrants of whom 30% are undocumented. Ninety-five percent of the undocumented population is from Mexico. Additionally, among the undocumented foreign-born working age population, 64% do not have health insurance.

2.4. Data analysis

We used an inductive approach to analyze the data and develop a conceptual model that was both grounded in our analysis (Corbin and Strauss, 2015) and structured by the social-ecological model (see Fig. 1). All Word documents and transcripts were imported into

Fig. 1. Relations among inequality, structure, stress and health.

MAXQDA, a qualitative data analysis software program (Verbi Software–Consult, 2017), and data were coded and analyzed. Team members used open coding (line-by-line reading of the text) to identify emergent themes and develop an initial codebook (Bernard and Ryan, 2010). During this stage of analysis, team members independently applied the coding schema to the same transcripts to assess inter-coder agreement (MacQueen et al., 1998). Codes and their application were discussed and the codebook was revised until group consensus (100%) was reached. Team members used in-vivo coding to apply codes to all Word documents and transcripts. Last, axial coding (i.e., constant comparison) was used to develop hypotheses regarding the relations between themes and narrative texts, identify the main study findings, and develop the conceptual model.

3. Results

3.1. The Eastern Coachella Valley

Locals characterize the unincorporated communities as populated by first generation foreign-born Mexicans, most of whom are undocumented, and some of whom are indigenous Mexicans from impoverished areas of southern Mexico. These include the Purépecha, an indigenous group from the state of Michoacán. Most live in poverty-stricken conditions. It is common for multiple families to live together in old, run-down, crowded trailers in parks with poor sanitation and infrastructure. This area, which is not “recognized” by the wealthier western valley residents, stands in stark contrast to the more affluent western valley cities where residents are native-born middle-to upper-class Americans or “snowbirds,” residents of colder climates that migrate to the western valley during the winter months. In their report, *Revealing the Invisible Coachella Valley*, London et al. (2013) highlight this contrast: “The lush golf courses, exclusive resorts, and celebrity sightings of the renowned Western Coachella Valley communities, such as Palm Springs, are worlds apart from the unpaved streets, failing septic systems, and unauthorized waste dumps of the Eastern Coachella Valley” (p. 2).

The valley itself is characterized by a checkerboard pattern of tribal and US government land. Coachella Valley is the tribal homelands of the Cahuilla Indians. However, in the late 1800s, this tribal land was subdivided into Bureau of Indian land (reservations) and US territory (Ainsworth, 1965). Every other square mile belongs to local tribes and non-tribal landowners (e.g., cities, towns). A number of trailer parks where Latino immigrants live are located on tribal lands, which are outside the jurisdiction of US federal and state governments.

These tribal lands both protect and further disenfranchise this population. On the one hand, this space creates a safe haven for undocumented foreign-born Latinos. While on the land, they are free from deportation. As soon as they leave tribal land, however, they risk deportation. Two community leaders who grew-up in the eastern valley in Mexican families recounted a time when they transported 20 undocumented Latino families from their flooded trailer park on tribal land to a temporary shelter. They explained:

We're just waiting for all the families to gather their belongings so that we can transport them to [the shelter]. So we're getting ready, and mind you, this is now about 8:30, 8:45 at night. And we see immigration drive by. So obviously, the owner of the trailer park called him. That's not the first time he had done that. I said, 'I cannot fathom the idea of being pulled over and having these parents deported and taken in front of those kids.'”

Continuing to narrate this experience, the other community leader added: “These are our kids. These are kids from [our schools]—these are not just like, you know, random people. These are people we have relationships with.” These community leaders feared their actions would lead to the deportation of the entire trailer park. With the support of a local political official, the border patrol were distracted,

buying them enough time to safely caravan the families to shelters where they were safe from US customs and border control officials.

This scenario illustrates a common pattern in local immigration practices. Latino immigrants without papers fear border patrol and do not leave their communities. A local pastor shared that about 70% of residents in the trailer park where his church is located were “without papers” (undocumented) and live in constant fear of *la migra* (US customs and border patrol). This region lies within the US government's 100-mile border zone—a space that gives Border Patrol agents extra-Constitutional powers including the operation of fixed immigration checkpoints (American Civil Liberties Union, 2018). The eastern valley is home to the Indio Station, one of four border stations in the El Centro Sector of the US Border Patrol. The Indio Station, established in 1936, initially patrolled farms and ranches in the valley to prevent undocumented farm laborers from travelling north to central California (<https://www.cbp.gov/border-security/along-us-borders/border-patrol-sectors/el-centro-sector-california/indio-station>). Today the station focuses on transportation checks for drug trafficking, smuggling, and contraband; however, border agents continue to patrol the valley's agricultural lands and are notorious for racially profiling brown-skinned individuals (Plevin and Maschke, 2018).

On the other hand, undocumented foreign-born Latino living on tribal lands face such unfair housing practices as inflated rent and have no legal protection. Many Latinos live in older, poorly insulated trailers that are cold in the winter months, hot in the summer months, and permeable to the dust of summer dust storms from the Salton Sea. The cost to heat and cool these poorly insulated trailers is double or triple that of a newer home. Some might pay as much as \$425 for rent and \$300–\$325 per month for air conditioning (Colletti et al., 2006). Because of the high cost of living and limited incomes, single trailers are often crowded (e.g., 10 people in a trailer) and house multiple families.

The discrimination and abuses this population faces extend to the workplace. The long history of exploitation of farmworkers in the valley continues today. Large agro-business farms hire subcontractors to find and employ labor during harvest season, further alienating labor from the land and business owners and exacerbating inequalities. During an unstructured interview with a local leader in the eastern valley, he indicated that anywhere from 3000 to 10,000 foreign-born Latinos work as farm laborers, a number that fluctuates in response to seasonal migration patterns. Approximately a third of residents migrate between California's eastern Coachella and central San Joaquin Valleys, depending on seasonal harvests (Colletti et al., 2006). These farm laborers earn about \$9 per hour and can work between 70 and 90 h a week during the peak season. “Everything is regular pay,” explained a male farmworker; there is no overtime pay. On a typical day, farm workers wake up before dawn and return home after the sun goes down. During the harvest season, farm workers might work at this mentally and physically demanding job seven days a week for weeks or months without a break.

As community members explained, migrants from Mexico and Central America leave their families, their homes, their communities, and their countries to find work. When they arrive in the valley, despite their contributions to the local economy and American food system, they face socio-economic and political disadvantage, inequalities, and extreme isolation. Such experiences foster feelings of despair, hopelessness, and disconnection, which, for some manifest psychological distress. A Mexican woman, who once worked the fields, explained, “There is an illness, a mental illness that is called the *Ulysses Syndrome*. This syndrome is specific to people who are far away from their families, their children, their spouse, who they had to leave behind, everything that was happening in their life [that they left behind].” Community leaders and farmworker advocates expressed that migrants from Mexico and Central American often suffer from the Ulysses Syndrome. This syndrome explains how migrants' exposure to adverse conditions and chronic and multiple stressors result in extreme emotional hardship, manifesting symptoms of psychiatric distress—such as

insomnia, anxiety, anger and irritability, migraines, and gastrointestinal pain (Achotegui Loizate, 2009).

3.2. Persistent and daily chronic strain

In what follows, we focus on three persistent and daily chronic strains that infringe upon self-concept and contribute to stress—low social status, lack of permanency in working and living contexts, and limited healthcare access. We situate our analysis in frameworks of structural vulnerability to show that this Latino population is vulnerable to everyday abuses, harm, and suffering even before they enter the valley due to outside external factors that, over time, have become internalized and incorporated into the social fabric of life in the Coachella Valley. We then use participants' narratives to illustrate that once in the valley, inequalities rooted in class, gender, race/ethnicity, geography, and citizenship shape their everyday lived experiences of social status, employment and housing permanency, and access to healthcare services. As delineated in Fig. 1, we show how these inequalities are constant and chronic and intimately shape self-worth, dignity, and wellbeing creating stress and resulting in poor mental health.

3.3. Social status

Low social status, influenced by the entanglement of citizenship, legal status, and social position (e.g., married, single, man, woman, fieldworker), was a chronic strain. One of the most present and persistent strains was legal status. "One of the main problems is they [farmworkers] don't have documentation. You have a lot of people without documentation," explained a farmworker advocate.

Farmworkers enter the fields to work, earn money, and find meaning in their life. Yet, because of structural violence, they are vulnerable to exploitation and social injustices that prevent them from living well and harm their health and wellbeing. This was evident in our initial conversations with community leaders and substantiated at the CRB. For example, when asked to consider the broader factors affecting farmworkers' health, an adult son of a Mexican farmworker said:

There is so much desperation. I think this desperation is more or less what we've found, this desperation of wanting to work to make money, to pay bills, but not only here, but also to help family in Mexico or other parts of Latin America. So, because of the desperation health is not that important. ..."

This excerpt highlights the connection between unfair working conditions (e.g., long days, little pay, no overtime pay), the daily struggle to survive, responsibilities to transborder families, emotional distress (i.e., desperation), and overall health and wellbeing (Organista et al., 2016). Confirming the meaning of this statement and building on it, a Mexican woman who had worked the fields and was now an advocate for farmworkers said:

We need to give credibility to the people working in the fields who are contributing to our community. What we need to give them is the importance, that their jobs are important, and that it is dignified [work], that they should feel proud to do their job... When we do this work, we have rights.

3.4. Permanency

Lack of permanency related to seasonal and non-contractual employment, no rental property or land use rights, and impermanent housing fostered a sense of insecurity that emerged across participants' narratives. Farmworker participants talked about the demands of the agro-business and employers' expectations for laborers to work until the crops are picked, packed, and shipped. A woman farmworker from Mexico explained:

They [bosses] don't care if you tell them you cannot come during the weekend. If there is only two people to pick up the crops, you cannot leave. Who is going to do the work for them? They have an order they need to deliver. The order must be completed by the next day, and we need to stay there to complete what they are requesting. It does not matter if the plants are not good anymore. It does not matter! We need to complete the order. And, if not, well, you get fired!

This excerpt highlights the precarious economic position of these farmworkers. If they complain or resist their employers' demands, they may lose their job. Because their work follows the growing season, their hours fluctuate with the seasonal harvest patterns. Many struggle to meet the daily demands of purchasing food and paying for school expenses, childcare, utilities, and rent, let alone transborder demands such as sending remittances to family in Mexico.

The possibility of getting fired was a constant strain and farmworkers' emotional selves and physical bodies suffered. Farmworker participants talked about their bodies hurting—their hands, waist, and shoulders ached. They also endured the brutal heat of the desert, which, in the summer months the day-time temperature can soar above 120 °F (~49 °C). Despite pain and exposure to severe elements, farmworkers feel as if they have to go to the field. They have to work. One of the consequences of working through such pain and suffering, as evidenced in the words of a young man whose father worked in the field, is alcohol use. He said, "My dad drinks after work to ease the pain of being in the field for hours." Alcohol, which is more commonly used by men, eased their physical and emotional pain (Worby et al., 2014.)

This lack of permanency follows them into their homes. The majority of farmworker participants owned their own homes, typically a trailer, but not the land where they parked their trailer. Evidence for the lack of permanency of their homes emerged from conversations with farm workers who described common landlord behaviors. A woman farmworker explained:

There is no bill here. They [landlords] just give you an amount. Whatever the owner of the parking spot says... He just says, 'This is the charge for rent and for the electricity. Pay it!' And, you can't really fight anything because that is what you got. If you don't like it, then, he says, 'Take out your trailer.'

The potential loss of their rental space and the permanency of their homes was stressful. Similar to using alcohol to ease physical pain, many used alcohol to deal with emotional and social problems. Alcohol helped them forget about these chronic strains. "It's a form of escape," said a Mexican farmworker advocate. Continuing, she explained, "People think that drinking, just like drugs, will make you forget all your problems."

3.5. Healthcare access

Another source of chronic strain was healthcare access. There are two outpatient primary care clinics in the ECV. For residents living to the west of the Salton Sea, there is an outpatient primary care clinic that operates twice a week. In addition, there are limited providers in the area. Estimates suggest there is one doctor for every 8407 residents of the eastern valley (Potter, 2012). Advocates, community members, farmworkers, and service providers explained most farmworkers do not have health insurance. For those that do, the co-pays are high, the process to get to the clinic or set up an appointment is cumbersome, and there are limited or no bilingual services. Additionally, some employers in the ECV offer their employees low-cost medical insurance, but only if they opt for medical coverage in Mexico. Eastern valley residents who opt for this coverage drive more than 100 miles and cross the US-Mexico border to receive care in Mexicali. If they want coverage in the US, it might cost upward of \$130 per month for a family of four. Minimum wage incomes and the high cost of living push some toward

healthcare in Mexico. Only those with documentation, the minority in the eastern valley, are eligible for this insurance plan.

Residents of the eastern valley also face cultural and structural barriers to care. Clinics in the eastern valley offer bilingual primary care services. Yet, they struggle to access bilingual and structurally competent mental healthcare services. A Mexican woman who is a farmworker advocate remarked:

You don't have access to bilingual psychologists or psychologists that cover people with low incomes. Because mental health in this valley—I don't know for others, it is very expensive. And you have to go through a process with MediCal that authorizes the therapy.

Even if farmworkers have insurance and access to bilingual care, some employers do not offer work contracts and do not provide sick leave. As evidenced by the following statement by a man who grew-up in a Mexican farm working family and now provides health screenings to valley residents, this has dire consequences. He said:

It is rare that an employer from here, the eastern Coachella Valley, gives an employee sick days. It's so rare: if you don't work, you don't get paid. A person who is sick would say, 'Wow! What, what will I do? I can work or lose—today, I can go to the clinic or lose an entire day of work.' And, for a person who is only making minimum wage, this is a very difficult situation. ...

In addition to weighing the economic costs, many must also consider their legal status and the type of documentation (e.g., healthcare insurance, personal identification) needed to access healthcare services. For many, lack of knowledge about needed documentation or questions about legal status creates fear, which becomes a major barrier to accessing healthcare services. Consequently, many wait to access services. "For this reason you find certain illnesses that are in the advanced stages, because people wait—they wait, they wait, they wait. And when they go [to the clinic], they are already really sick," explained a healthcare service provider who grew-up in the eastern valley and whose parents were from Mexico and worked the fields.

4. Discussion

Mainstream conversations about Latin American migration often reference weak economies, corrupt political systems, and organized violence as causes of human migration from Mexico and Central America to the US. Such conversations assume immediate contextual factors (economic, political, and social) prompt immigrants to make individual-level choices and weigh the perceived benefits/costs and risks of leaving their place of origin and emigrating abroad (Holmes, 2013b). While these immediate factors certainly shape migration decisions (Schiffrin, 2017), they constitute only part of a very complex and layered decision-making process also informed by cultural and historical contexts and geopolitics. For instance, migration trends from Mexico to the US indicate more women, educated persons, and residents of southern and central Mexico cross the border, and they tend to remain in southern California (Marcelli and Cornelius, 2001).

Mexican families have an intimate connection to the lands of southern California—they once owned the land and then following dispossession, they worked the land (Pitt, 1998). The history of Spanish-speaking populations in the ECV plays an important role in Mexican and Central American persons' migration decision as it provides the context for the fluidity of geopolitics, exploitation, political intimidation, and legal surveillance in this region. Furthermore, this historical context shapes the experiences of migrants who arrive in the valley. Even before they arrive, they face disadvantage because of the social positions and statuses they hold in their country of origin. Mexicans are one of the least educated foreign-born groups; are more likely to live in poverty compared to the total foreign-born and native population; and compared to the overall immigrant population are much less likely to be naturalized US citizens (Zong and Batalova, 2016).

Brazilians are the only other foreign-born population in the USA estimated to have a higher proportion of undocumented migrants and lower rates of naturalization (Marcelli et al., 2009). Furthermore, Mexicans involved in farm work may have lived in rural communities in their home states where they likely had little economic or educational opportunity (Duke and Gomez Carpineiro, 2009).

Once in the valley, migrants face chronic sources of strain linked to low social status, lack of permanency, and limited healthcare access. First, they experience aggressive immigration and local law enforcement—as they act out their daily lives, they are in constant fear of border patrol, local police, and others in positions of power (e.g., landlords). They experience structural racism. What Philbin and colleagues (2017) found directly results in stress and indirectly impedes access to social institutions, healthcare services, and resources (Sabo et al., 2014). Second, they experience unfair housing practices. For instance, for foreign-born undocumented and indigenous Mexicans, tribal lands are a site of refuge; places where many feel protected. Yet, these lands are also sites of inequality. Third, they lack access to essential resources including healthcare services. Anywhere from 36 to 70% of residents in the ECV either cannot afford healthcare or are not eligible for Medicaid or Medi-Cal because of their legal status (<https://yourcprmd.com/combating-healthcare-access-disparities/>). Yet, even if they have insurance, they may not have the financial resources to afford co-pays, pay for medications, or even take sick leave. Furthermore, as our work and others show, undocumented status and the fear of disclosure limits undocumented Latinos access to healthcare services (Berk and Schur, 2001; Vargas Bustamante et al., 2012).

In general, Latino immigrants face a number of barriers to healthcare services use and consistently report limited or no healthcare insurance coverage, undocumented status, and low incomes as common and significant barriers to care (Chavez, 2012; Martinez-Donate et al., 2014; Vargas Bustamante et al., 2012). Foreign-born Latinos report confusion in navigating healthcare systems, doctor-patient (mis)communication, and lack of bilingual providers and interpreters as persistent barriers to accessing quality, culturally competent, healthcare (Harari et al., 2008; Ransford et al., 2010). Latinos may also fear legal consequences (e.g., deportation) if they, or family members, seek healthcare services (Heyman et al., 2009). Echoing others' work, our study found that irrespective of nativity, nationality, and race/ethnicity, Latinos in rural communities face even greater barriers to healthcare access due to their geographic isolation (Casey et al., 2004; de Jesus Diaz-Perez et al., 2004).

5. Limitations

Our study provides a vivid picture of the health consequences of life events and persistent and chronic strain among foreign-born Mexicans in farm working communities; however, limitations should be considered. First, the majority of respondents were women, which does not represent the national gender distribution among farmworkers. According to the 2013–2014 National Agricultural Workers Survey, 72% of farmworkers are men (Hernandez et al., 2016). While we initially set out to engage men in the study, the dynamics of our research team, which included two college-educated White women and a college-educated bicultural Mexican American woman, was a significant barrier to engaging foreign-born Latino men. We expanded our team to include a foreign-born male from Mexico and a Mexican-American male university student who grew up in the ECV and was involved in the community through internships and community service. While we attempted to set up several all-male focus groups, we were only able to organize and carry out one focus group. As we discuss elsewhere (Rodriguez, Newkirk, Maximo Anastacio, & Cheney, nd), gender norms and expectations (e.g., *machismo*) created significant barriers to engaging this Latino male population.

6. Implications

Our work builds on previous work on structural determinants of health (e.g., Link and Phelan, 1995) and provides a rich, contextualized understanding of the cumulative effects of disadvantage on the health and wellbeing of Latinos (Lewis and Burd-Sharps, 2018). The findings have implications for nonprofit organizations and public healthcare systems. Within these systems, administrators, social workers, providers, and researchers are increasingly aware of the impacts of social determinants (e.g., income, English proficiency, and education level) on health outcomes (Juarez-Ramirez et al., 2014). Many are less aware or unable to recognize the structures that have historically produced and continue to reproduce inequalities in health. This is likely because of an overemphasis on empirical, measurable data (i.e., lack of transportation is correlated with missing healthcare appointments), which generates insight into more immediate solutions (e.g., increased access to transportation) rather than long-term structural change.

Nonprofits, healthcare systems, policy makers, and researchers can engage in actionable steps to address structural-level impacts on health. Questions need to be asked: What resources exist and how can they be used? How, and in what ways, can existing resources be used to create long-term solutions? For instance, by understanding that certain sectors, such as migration and local police, inflict intimidation and exploit vulnerable groups, nonprofits and healthcare organizations can collaborate with community leaders and action- or community-based researchers to develop solutions. Furthermore, if current healthcare services are providing the needed care but foreign-born populations are not able to access this care, then how can we use information gleaned from studies such as the one discussed in this paper to inform healthcare or immigration policy change?

Such immediate solutions may include developing relationships with local or international governments (e.g., foreign ministries of health) to create collaborations and accumulate resources to facilitate healthcare service access in immigrant communities. The Mexican government is already doing this through its implementation of *Ventanillas de Salud* (Health Windows), which provides healthcare screenings, health education, and referrals to government and non-government healthcare organizations throughout the Mexican Consular network (Rangel Gomez et al., 2017). While this program brings health resources to foreign-born Mexicans and other Latinos in the urban US, it has not yet reached these Latino populations in the rural US. For this program to reach all, key federal, state, and local institutions such as nonprofits, local governments, healthcare organizations, and medical schools should consider this program as a vehicle to engage foreign-born Latino populations.

The knowledge generated through this study can inform future research. Our work provides a contextualized understanding of the relations between low social status, stress, and poor health outcomes among foreign-born Latinos. Does this relationship hold true for non-foreign born Latinos? This research was conducted in rural contexts. Are there potential geographic differences in the relations among social status, stress, and health among rural and urban foreign-born Latinos?

7. Conclusions

This study gives voice to the voiceless in an effort to influence public understandings of the immigrant experience and provides evidence that can inform public health and immigration policy change (Hansen et al., 2013). By articulating the connections between macro- and micro-level processes, we have shown how inequalities across multiple social systems position foreign-born Latinos in low social statuses in the US rendering them vulnerable to persistent and chronic strain that affect health and wellbeing. Our work emphasizes the importance of considering the historical processes (e.g., colonialism, forced repatriation) and situational factors (e.g., current healthcare and immigrant-related policies) of social groups to better assess the effects of inequalities on the

health of structurally vulnerable populations.

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