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Health Care Access Among California Farmworker Households in the Desert Southwest

DISSERTATION

submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in Social Science

by

Kathryn Azevedo

Dissertation Committee:
Professor Arthur J. Rubel, Chair
Professor Francesca M. Cancian
Professor Leo R. Chavez

2000

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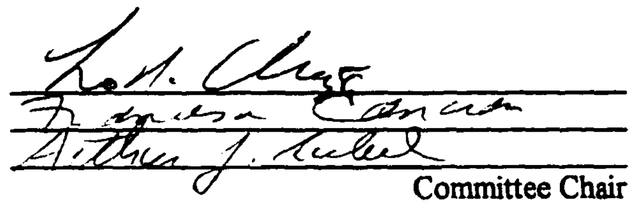

Committee Chair

University of California, Irvine
2000

DEDICATION

Dedicated to the people around the world who grow, pick, and harvest our food.

" El Sol Que Tu Eres"

Sol redondo y colorado
Como una rueda de cobre
De diario me estás mirando
De diario me miras pobre

Sol lo tú eres
Tan parejo
Para repartir tu luz
Habías de enseñarle al amo
A ser lo mismo que tú

Me miras con el arado
Luego con la rozadera
Una vez el la llanura
Y otra vez en la ladera.

Author Unknown

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CURRICULUM VITAE

Kathryn Azevedo

1992 B.A. Social Science Field Study in International Health,
Title: Primary Health Care Models
University of California, Berkeley

1994 M.A. Masters of Arts in Social Science,
Title: Political Economy of Rural Rehabilitation in Sinaloa, Mexico
University of California, Irvine

1992-97 Teaching Assistant in the following classes: Anthropology, Medical Sociology, Political Science, Psychology, & Sociology
University of California, Irvine

1994-98 Research Assistant, Department of Anthropology,
Professor Benjamin N. Colby, University of California, Irvine

1997 Research Assistant, Department of History,
Professor Gilbert Gonzalez, University of California, Irvine

1996-97 Field Researcher, Casals & Associates under contract with the Centers for Disease Control & Prevention

1999 Field Researcher, California Institute for Rural Studies

2000 Ph.D. in Social Science, Program in Social Relations,
University of California, Irvine, Dissertation:
Health Care Access among Southwestern Farmworkers Families
Professor Arthur Rubel, Irvine, Chair

PUBLICATIONS

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ABSTRACT OF THE DISSERTATION

Health Care Access Among California Farmworker Households in the Desert Southwest

By

Kathryn Azevedo

Doctor of Philosophy in Social Science

University of California, Irvine, 2000

Professor Arthur J. Rubel, Chair

This research inquiry aims to understand what processes most substantially impact potential access and realized access to primary health care for farmworker families in California. Potential access refers to the availability of medical services relative to need, while realized access refers to the use of medical services to satisfy those needs (Khan and Bhardwaj, 1994). Key to this research is how the condition of migrating outside one's county of residence affects access to medical services. In this study, political economic policy analysis focuses on how rural health care access at the local level is affected by federal, state, and local health care policies, which work either to secure or to undermine allocations of medical resources for these workers. This research argues that structural policies inherent in public and private health insurance programs for farmworkers are strong determinants of access to medical services.

CHAPTER 1: INTRODUCTION

Worldwide, agricultural laborers struggle to meet the basic needs of their families, doing work that remains arduous and low paying and that entails substantial occupational health risks. In the United States, research studies continue to document the exploitation experienced by this hard working, but socially invisible, occupational group (Bade 1993; Barger and Reza 1987; Griffith and Kissam 1995; Guendelman 1991; Johnson 1985; Koos 1957; Martin and Martin 1994; Palerm 1994; Rothenberg 1998; Wells 1996). Farmworker experiences have even received international attention. For example, in 1993 a commission was set up to investigate alleged human rights abuses among migrant farmworkers in the United States. Relevant to this present study of health care access among farmworkers, were the following findings reported in 1993 by the Commission on Security and Cooperation in Europe:

> Concerns which emerged included: ... unsafe exposure to toxic pesticides and chemicals; substandard housing, racial discrimination, restricted movement; restricted access to health care; unsafe and potentially deadly transportation; and inadequate or ineffective law enforcement mechanisms. The Commission found, as did a February 1992 report by the United States General Accounting Office, that in many cases, migrant farmworkers are not adequately protected by federal laws, regulations, and programs. As a consequence, their health and overall welfare are at risk.

According to this commission's study, restricted access to medical services is one of many prominent issues facing farmworkers. By evaluating access to health care among farmworkers, this research seeks to produce policy relevant recommendations.

The low-income California residents who are the focus of this research are California's working poor– farmworker families. This occupational group is unique in that many safety regulations governing other occupational groups are not applied to agricultural labor. In the midst of California's agricultural prosperity, this group of workers remains largely hidden in our society.

Research Question

From a perspective of a political economy of health, this research examines health care access, specifically defined, under two labor patterns: 1) when farmworkers migrate, and 2) when they are working in homebase areas. More specifically, this research inquiry aims to understand what processes most substantially impact both potential access and realized access to primary health care and basic emergency services. Potential access refers to the availability of medical services relative to need. Realized access refers to the use of medical services to satisfy those needs (Khan and Bhardwaj 1994). This research examines the hypothesis that a difference *is observed in potential access and realized access to medical care services between migrating and non-migrating farmworkers.* Thus, this study considers how potential and realized health care access differs as farmworker families migrate for agricultural work. This research effort examines how public, private, and charity health policies affect access to medical care of farmworkers and their children under these two conditions.

It is useful to provide a brief background of what is already known about the lives of farmworkers in the United States. These introductory sections elaborate on the migration patterns, occupational hazards, and medical services designated for agricultural

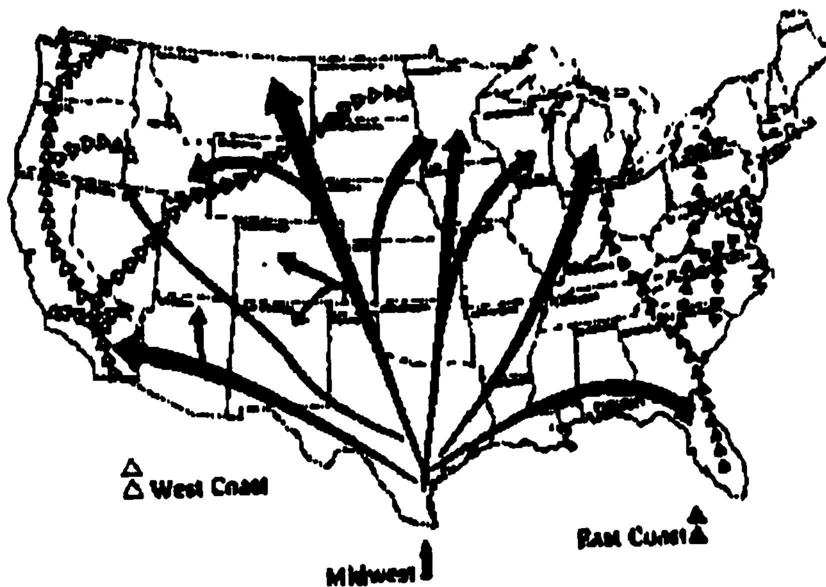
workers in the United States. First, a brief summary of the general travel patterns that many workers follow is briefly discussed below.

Migrant Streams– Traveling for Work

Estimates on the number of agricultural workers throughout the United States range from 1,000,000 to 5,000,000. The most commonly cited figure estimates the total number of migrant and non-migrating farmworkers and their dependents to be approximately 4,200,000 nationwide (Quandt et.al. 1998; Dever 1993). Growers in the state of California hire the most farmworkers. A 1993 study estimates that the total of migrants, non-migrating farmworkers, and their dependents in a given year stands at around 700,233 persons in California (Larson and Plascencia 1993).

The migratory patterns of agricultural workers are referred to in the literature as "streams". Three major streams are described– the East Coast, Midwest, and the West Coast streams. Characteristic of each stream is a "homebase" downstream, where these laborers reside and work when they are not traveling (Dever 1993; Benavides-Vaello and Setzler, 1994). This study focuses on a group of agricultural workers who are homebased in the southern part of the West Coast stream. Please refer to figure 1.1, which was originally published by the National Migrant Referral Project (1992).

FIGURE 1.1: MIGRANT STREAMS



Source: National Migrant Referral Project, Inc (NMRP)

NMRP renamed to National Center for Farmworker Health Inc.

The homebase area where I conducted this research project is located in a desert portion of the Southwest bounded on the west by the Coachella Valley and on the east by Yuma, Arizona. Many low-income farmworker families now live here because of the lower costs of living, the close proximity to Mexico, and the abundant agricultural work available due to irrigation from the Colorado River.

Two groups of farmworker households emerge: those who migrate and those who do not. Migrant farmworkers can be distinguished from non-migrating (sometimes called seasonal farmworkers) farmworkers because they travel and live in temporary housing, in non-homebase "upstream" areas, for at least half of the year. Non-migrating farmworkers in this study, however, typically return to their place of residence in the Coachella Valley at the end of a day at work. At this point, it is useful to introduce the health conditions seen among farmworkers and their dependents.

General Health Conditions Seen Among Agricultural Workers

The general health conditions reported among farmworkers illustrate the need for access to medical care services and have received attention. In 1992, Alan Dever conducted the first national survey of morbidity among farmworkers. Dever tested the hypothesis that Latino migrant and seasonal agricultural workers differ in health status from the Hispanic population and the general population per se. Other researchers, most notably Sakala, Slesinger, Ruducha, etc. have also examined the medical conditions that farmworkers experience.

Sakala found that farmworkers suffer from a multitude of health conditions. These medical issues are related to the consequences of primary and secondary occupational hazards. *Primary* occupational hazards include pesticide exposure, sun exposure, work

injuries, and poor field sanitation. Field sanitation refers to access to clean bathrooms, drinking water, and water to wash with. *Secondary* occupational hazards result from structural and institutional barriers such as difficulties in obtaining health care services, exclusion from traditional workers' benefits, lack of enforcement of health and safety standards, shortage of adequate and affordable housing, and the lack of access to clean drinking water (Sakala 1987). As a matter of comparison, Dever's work demonstrated that farmworkers have more clinic visits for diabetes, ear infections, pregnancy, hypertension, contact dermatitis, and eczema than both the general population and the Hispanic population in urban areas (Dever 1993). Furthermore, exposure to heat and sun can cause acute heat exhaustion, heat stroke, skin cancers, and eye cataracts. Injuries also result from unsafe transportation. In addition, poor field sanitation results in prolonged urine retention, and consequently urinary tract infections are seen at 20 times the national average (Sakala 1987; Migrant Health Resource Program 1993).

Dever's investigation also demonstrated that, demographically, farmworkers represent a younger patient population than the general US population. Other research indicates that farmworkers and their dependents suffer disproportionately higher rates of infant mortality and morbidity, premature birth, and developmental deficits (Ruducha 1989). They also experience infections, parasitic diseases, and chronic diarrhea more so than non-farmworkers. Chronic illnesses such as heart disease, gross gum disease, diabetes, and uncorrected vision defects are prominent. Muscular skeletal injuries (especially the back), hearing loss, and nutritional deficits such as anemia are also seen to a greater extent among farmworkers and their families (Thu 1998; Sakala 1987; Dever 1993). Moreover, HIV infection and tuberculosis are significant in this mobile population

(National Migrant Resource Program, 1993). Dever's assertion that farmworkers display an infectious disease cycle is also supported by earlier research (Sakala 1987). Dever's research also indicated that farmworkers are seen for a condition referred to as "strong anger," a mental health syndrome (Dever 1993). Table 1.1 highlights illnesses most commonly seen among farmworkers in the United States.

TABLE 1.1: Farmworker Illness Profile

Sun exposure: heat exhaustion, heat stroke, skin cancer, eye cataracts

Unsafe transportation: injuries from automobile accidents

Field sanitation: prolonged urine retention: increased risk for urinary tract infections

Direct occupation risks: contact dermatitis, muscular skeletal and repetitive motion injuries, pesticide exposure

Infections: Parasitic diseases, chronic diarrhea, tuberculosis, HIV

Chronic illness: Diabetes, gross gum disease, anemia

Mental health: "strong anger," depression, domestic violence

Sources: Alvarez 1985; Ciesielski et al. 1994; Dever 1993; Littlefield 1987; Maguire 1972; Mines 1982; Reeder et al. 1974; Ruducha 1979; Slesinger 1979, 1993; Vaughan 1993; Wilk 1986, 1993

In light of the morbidity seen among farmworker families, a nationwide system of primary health care clinics began operation in the 1960s as public pressure mounted to improve health, working, and living conditions for farmworkers working in the United States. This resulted in some protections for farmworkers in the areas of housing, pesticide application, and education for the children of migrant laborers. Additionally, in 1964 a federally funded Migrant Health program was established and continues to expand in the 1990s. The following section discusses this important program.

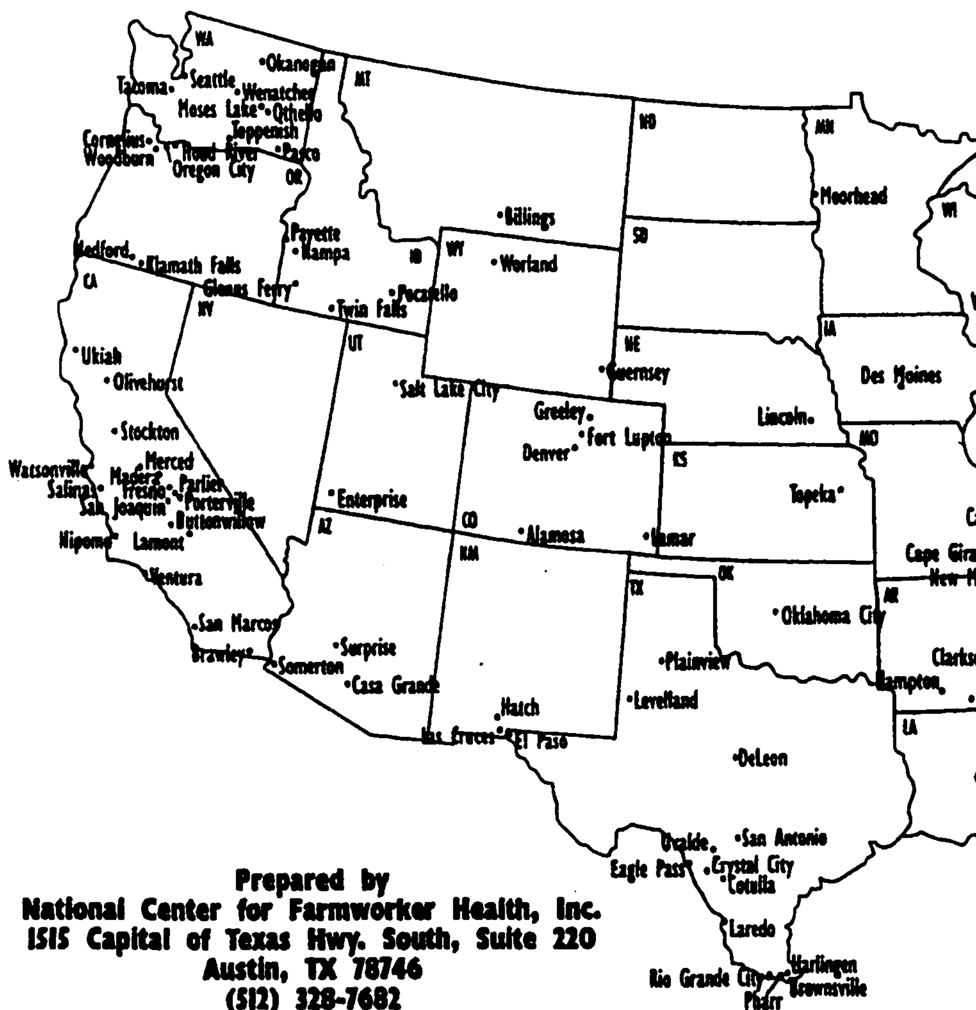
Medical Services Designated for Agricultural Workers in the United States

Community and Migrant Health Centers (CMHC), supported by the United States Public Health Service and sponsored by the Migrant Health Program (MHP), are federally funded primary health care clinics responsible for addressing the needs of migrant farmworkers. Of the major federally funded programs targeted towards migrant farmworkers, the Migrant Health Program is the oldest (Martin and Martin 1994).

Today there are approximately 144 Migrant Health Centers, supported by numerous satellite clinics, which provide prenatal, primary prevention, dental, nutrition, family planning, emergency/after hours care, health education, HIV care, pharmacy services, etc. (US Department of Health and Human Services, HRSA, 1998; MESA 1995). Please refer to Figure 1.2 on the following page to view the nationwide distribution of CMHC clinics.

FIGURE 1.2

HEALTH CENTERS SER
AND SEASONAL FA



Prepared by
National Center for Farmworker Health, Inc.
1515 Capital of Texas Hwy. South, Suite 220
Austin, TX 78746
(512) 328-7682

November 1997

FIGURE 1.2

CENTERS SERVING MIGRANT SEASONAL FARMWORKERS

Even though federal funding is granted to approximately 400 clinic sites nationwide, at which there are approximately 500,000 clinic encounters per year, it is estimated that these centers only provide care for approximately 13 percent of the farmworker population (Benavides-Vaello et al. 1994; Wilk 1993; Rust 1990). Therefore, despite the introduction of the Migrant Health program in the United States and political commitments to providing health care to farmworkers, this population continues to be one of the most underserved groups in the United States.

In California, there are 17 CMHC clinics. Together they comprise approximately 109 clinics serving farmworkers and other low-income persons in California (US Department of Health and Human Services, HRSA, 1998). Southeastern Riverside County and Santa Clara County are the geographic areas where the research for this present study was conducted. Both counties lack CMHC clinics. However, both research sites are served by primary health care clinics.

In the Southern California homebase location in Mecca, *Clinicas de Salud del Pueblo,* based in Brawley, California, provides medical services for farmworkers in Southeastern Riverside County in its satellite clinic. Therefore, this CMHC located in Imperial County is serving the needs of farmworkers in another county an hour north. In the Northern Californian "upstream" research site, located in Santa Clara County, migrant farmworkers are seen by staff at the *Rota Care* in the Art Ochoa Migrant Health Center in Gilroy, California.

Therefore, in both field sites chosen for this research project, farmworker households lived in close geographic proximity to a primary health care clinic. Both clinics described above have the capacity to refer patients to other medical sites for more

specialized care. The farmworker households in this study resided within a short distance, less than a mile, from a medical clinic for at least part of the year. With this research design, the geographic location of the medical clinic was less likely to function as an access barrier and thus it allowed for closer examination of the policy-related issues. Figure 1.3 on the following page illustrates the CMHC in California.

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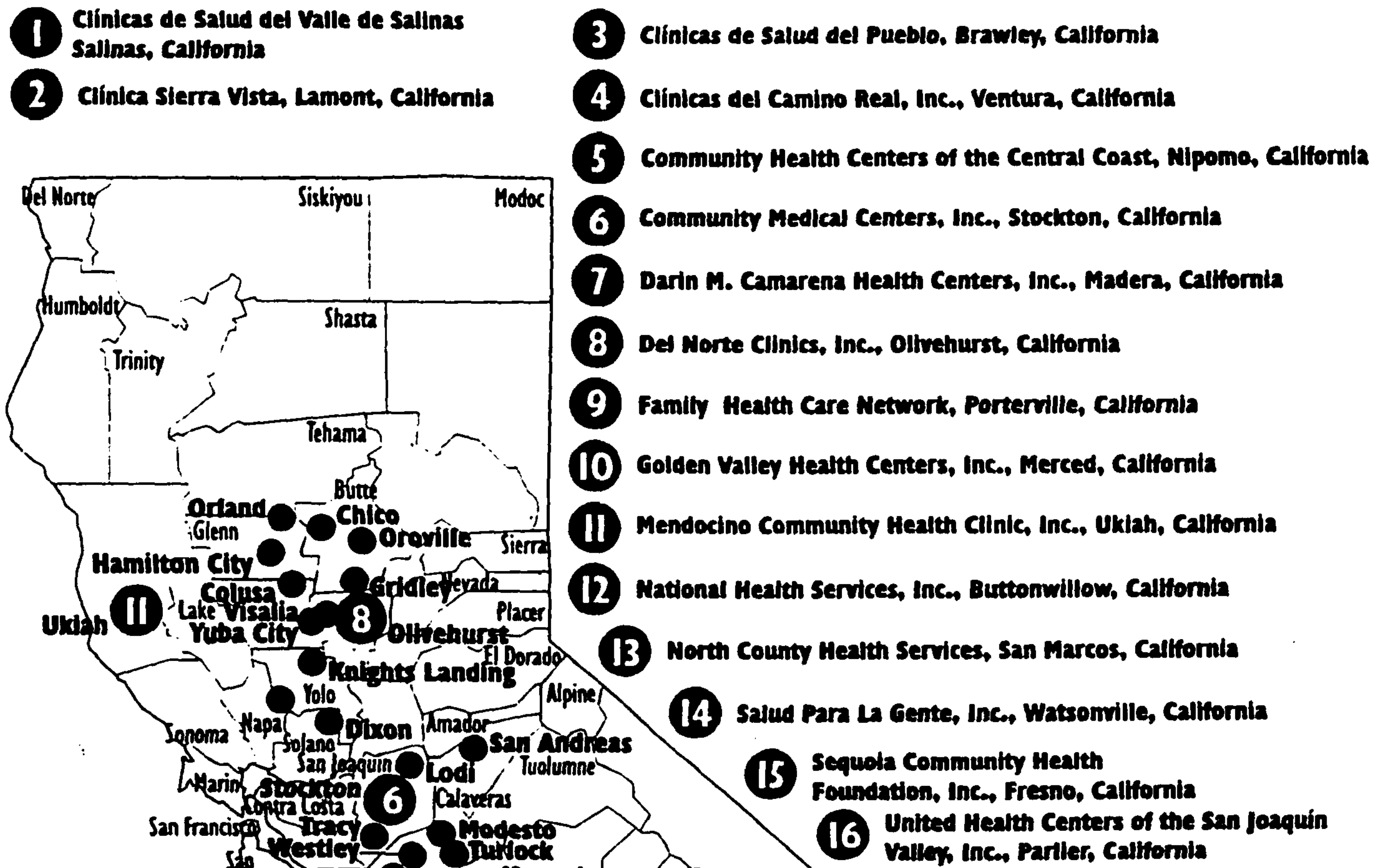
COMMUNITY AND MIGRANT HEALTH CENTERS IN CALIFORNIA

FIGURE 1.3



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9 Family Health Care Network, Porterville, California

10 Golden Valley Health Centers, Inc., Merced, California

11 Mendocino Community Health Clinic, Inc., Ukiah, California

12 National Health Services, Inc., Buttonwillow, California

13 North County Health Services, San Marcos, California

14 Salud Para La Gente, Inc., Watsonville, California

15 Sequoia Community Health Foundation, Inc., Fresno, California

16 United Health Centers of the San Joaquin Valley, Inc., Parlier, California

17 Valley Health Team, Inc. San Joaquin, California

● = satellite clinic

Why access to medical services has remained difficult for farmworkers has been examined by a variety of social scientists. The following chapter summarizes how medical social scientists have looked at this important social science issue.

CHAPTER 2: SOCIAL SCIENCE & HEALTH CARE ACCESS

Researchers who study health care access comprise an eclectic group from a variety of the applied medical social sciences. The literature reviewed in this chapter is interdisciplinary, drawing on the fields of medical economics, public health, environmental health studies, health policy studies, medical sociology, and medical anthropology. It is imperative to discuss how medical social scientists have examined health care access among Latino populations in the United States.

Health Care Access Among Latinos- Previous Studies

Previous ethnographic research on Spanish-speaking farmworkers of Mexican origin indicates that they comprise a medically pluralistic population that seeks modern medical care services (Bade 1999; Barger and Reza 1994; Chavez 1994, 1992, 1986; Galarza 1964; Harthorn 1998; Johnson 1985; Martin and Martin 1994; Slesinger 1992 Trevino et al. 1996; Watkins 1990). Some studies emphasize how cultural factors influence a worker's decision to seek medical care, and other studies examine how structural and policy variables influence health care access.

Certain studies on health care access among Latino immigrants examine how underlying cultural and social processes influence access to medical services (Bade 1993; Chavez 1995; Chi et al. 1992; Kearney et al. 1987; McGreevy 1993; Scheder 1988). For example, cultural perceptions of illness, sickness, and disease as well as interactions with medical personnel influence when and how a recent immigrant decides to seek care. These types of studies are meaningful especially when they address access among a new immigrant group. For example, Bonnie Bade's work on health care access among Mixtec farmworkers focuses on the unique cultural perceptions among this Mixtec speaking

group who have only recently participated in California agriculture (Bade 1992).

Other investigations examine how structural and policy variables affect access to medical services. For example, these studies focus on specific variables, such as how the lack of health insurance impacts utilization of medical services among specific Latino populations (Chavez 1986; Hubbell 1991; Slesinger 1992). These studies uncover structural inequities by means of a political economic analysis of access to medical services. This research project is similar in that it examines how structural health policies influence potential and realized health care access among California resident farmworkers. At this point it is useful to explore the many definitions of health care access in the literature.

Definitions of Health Care Access

Despite past efforts to clarify "access to health care services," there are multiple dimensions and meanings associated with this concept. The meaning of health care access has remained elusive because many authors discuss the concept without directly defining it (Khan and Bhardwaj 1994). For example, some studies done on agricultural workers assert that health care access is fundamental to the research endeavor. However, the meaning of access is assumed. Penchansky and Thomas point out that, "The problem is not limited to the lack of a precise definition of access, or the multiple meanings given to the term; access is also used synonymously with such terms as accessible and available, which are themselves ill defined" (Penchansky and Thomas 1981).

In the vast literature on health care access, some studies have conceptualized and defined health care access. The following is a summary of the work of Bashshur and Webb, Penchansky and Thomas, Bureau of Health Planning, C.E. Lewis, Khan and

Bhardwaj, Lynn Morgan, and Merrill Singer. This discussion lays the theoretical foundation for this research.

Bashshur and Webb define access to health care as "the ability to obtain health care services when needed" (Bashshur and Webb 1992). They cite geographical and economic factors as major barriers in using medical services. Thus, an accessible health care program is one in which clients can get to and from services with reasonable effort. This structural aspect of health care access refers to transportation, distance, and geographical location of the medical clinic. Another indicator of health care access, according to Bashshur and Webb is third party insurance coverage. However, even health care coverage does not assure utilization of medical care services. Other factors that facilitate access "include the availability of health care facilities or resources within a reasonable distance from where people live, the relative magnitude of opportunity and indirect costs incurred when using health services (such as time and/or wage losses), and the level of human effort involved in the journey for care" (Bashshur and Webb 1992). Although Bashshur and Webb's brief discussion provides a good general description of health care access, examination of specific access variables is lacking.

Penchansky and Thomas provide "a taxonomic definition of access, one that aggregates the broad and ambiguous concept into a set of dimensions than can be given specific definitions and for which operational measures might be developed" (Penchansky and Thomas 1981). Going further, they conceptualize access with more specific dimensions in which there is a "degree of fit" between the health care system and the patient. Dimensions important to their model include the variables of availability, accessibility, accommodation, affordability, and acceptability (Penchansky and Thomas

1981). Khan and Bhardwaj critique the work of Penchansky and Thomas by asserting that they do not "provide a framework that would explicate the nature and levels of interaction among the dimensions ... their taxonomic definition of access does not yield a comprehensive typology of access ... and ... [they] also largely ignore an integral aspect of the access concept, namely barriers to access, which is intricately linked with the widely accepted notion in the literature that access refers to the ability to obtain needed services" (Khan and Bhardwaj 1994). I assert that Penchansky and Thomas's contribution lies in their notion of acceptability as an access variable even though they do not specify what contributes to user acceptability of medical services.

The Bureau of Health Planning, however, does get more specific. A definition of health access that clarifies "accessibility" and also incorporates barriers to access was articulated in a 1979 publication put out by the Bureau of Health Planning. Health care "accessibility" is defined as, "the ability of a population or a segment of this population to obtain available health services. This ability is determined by economic, temporal, locational, architectural, cultural, organizational, and informational factors which may be barriers or facilitators to obtaining services" (Bureau of Health Planning 1979). This definition is useful because it is concise and comprehensive. But, the definition emphasizes user barriers and facilitators. Although the user, the farmworker, is the focus of this research inquiry, it is also important to discuss access from the perspective of medical providers.

The work of C.E. Lewis addresses this concern. Lewis elaborates and emphasizes the importance of barriers to access by arguing that an effective way to define access to health care services is to define access in terms of the barriers (Khan and Bhardwaj 1994

citing Lewis 1977). These barriers include the "number of providers, their geographic distribution, their type of practice (general, specialty, subspecialty), the organizational arrangement of providers (solo, group practice, hospital, urgent care) and the scope of the service they provide (medical, surgical, nursing, rehabilitation)" (Khan and Bhardwaj 1994). Other important consumption barriers include economic and psychosocial barriers that are related to health and illness behavior (Khan and Bhardwaj 1994). Lewis argues that "there must be responsibility of providers in terms of number, location, and temporal coverage before access can be realized and on the consumption side, economic barriers are probably greater than those related to health and illness behavior" (Khan and Bhardwaj 1994 citing Lewis 1977). Khan and Bhardwaj utilize Lewis's ideas on access barriers. They point out, however, that Lewis did not include a discussion of "the barriers to access imposed by the preferences or prejudices of providers and patients" (Khan and Bhardwaj 1994). Despite this omission, Lewis's work lays the foundation for Khan and Bhardwaj's ideas on access.

Khan and Bhardwaj, following Aday et al., explain health care access as it relates to the provision of health care services by defining it as a measure of potential versus actual entry "of a given population group into the health care system" (Khan and Bhardwaj 1994). Thus, "potential access" and "realized access" represent the key concepts at the root of Khan and Bhardwaj's schematic model of access to health care. This model asserts that a

> population's potential access to health care services basically relates to the availability of health care resources (facilities and personnel) relative to their needs for services, and realized access relates to the actual use of such resources

to satisfy these needs. And use is greatly influenced by availability, as well as by the inherent characteristics of the service system and those of the potential users, which express themselves as either barriers or facilitators (Khan and Bhardwaj 1994).

Khan and Bhardwaj's definition of health care access is clearly articulated and can be translated at the level of methodology. This research study will utilize Khan and Bhardwaj's distinction between potential and realized health care access. Moreover, this definition is embedded in a political economic analysis that attempts to explain the interactions between micro-level behaviors with macro-level socio-political policies. The following discussion elaborates on examining health care access from the political economy of health framework in medical social science.

Health Care Access and the Political Economy of Health Framework

Overall, this study asserts that structural policies inherent in public and private health insurance programs for farmworkers are determinants of access to medical services. These forces, which are embedded in socio-political processes, explain who uses these medical services, why and how they do so, what type of care they receive, and where they go for these services.

Medical anthropologists, utilizing the theoretical framework of the political economy of health, challenge health care planners to consider multiple levels and layers of economic, cultural, and political influences. This research utilizes a modified version of Lynn Morgan's definition of political economy of health which examines the effects of stratified social, political, and economic relations within the world economic system (Morgan 1987:132). Political economy of health is defined in this study as a critical and

historical theoretical framework for analyzing health policy in a market economy. More specifically, public, private, and charitable programs are examined in order to illustrate how their policies influence potential and realized health care access among farmworkers employed in California agriculture. Characteristic of political economic analysis, this research concentrates on examining access in terms of how health insurance policies impact the use of medical services by farmworkers in California. Important to the analysis are the perspectives, in their own voices, of farmworkers interviewed where they live and work.

In this study, political economic analysis has the potential to reveal the political, economic, and clinical consequences of current health care policies for low-income farmworkers in California since access to medical services is understood as a social process determined by the characteristics of the health care system and its potential users (Singer 1994). In particular, this study attempts to understand how health insurance policies, influenced by external political processes and economic priorities, ultimately impact farmworker access to basic primary and emergency medical services in California.

To collect appropriate data at each level of analysis, a community-based fieldwork methodology was utilized. The following chapter elaborates on this research process.

CHAPTER 3: COMMUNITY BASED FIELD METHODOLOGY

This research implements an "ethnostudy" methodological approach; it combines ethnographic work, in the form of open-ended, semi-structured interviews and participant observation, with survey research (Griffith and Kissam 1995). Qualitative and quantitative research methods are integrated into a multi-methods approach.

Fieldwork occurred over a six-year period. Beginning in November 1994 through June 1996, in-depth interviews with 75 key informants provided the necessary background for the development of the questionnaires. This process was followed by a pre-test of the structured questionnaire from August 1996 through September 1996 in which farmworker households were interviewed at the Art Ochoa Migrant Housing Center in Gilroy, California. From February 1997 through June 1999 farmworker households in Mecca, California were interviewed along with farmworker advocates, health care practitioners, merchants, and local political leaders. Overall, data was collected on 130 households that included 560 people– 238 adults and 322 dependents under the age of 18. Each of these households had at least one member who was a full-time farmworker for at least nine months of the year. Of the 238 adults, 180 men and women identified themselves as full-time farmworkers.

Field Sites

All households interviewed, both migrating and non-migrating, were homebased in the desert agricultural areas of southeastern California and western Arizona. Farmworker households were interviewed in Mecca, located in the Coachella Valley in Southern California, and Gilroy located in Northern California.

Upstream- The Art Ochoa Migrant Center: Gilroy, CA

Each agricultural season, migrating farmworkers homebased in Southeastern California live temporarily "upstream." Farmworkers in these households work year round in agriculture and maintain a residence in the study area. In the winter, they live in cities like Indio, Mecca, Thermal, Yuma, etc., but during the spring, summer, and early fall they work in central and northern California localities such as Huron, Coalinga, Salinas, and Gilroy. One migrant location is the Art Ochoa Migrant Housing Center in Gilroy, California. Figure 3.1 illustrates the location of this migrant family housing center.

More specifically, the Art Ochoa Migrant Housing Center has 96, two bedroom units available to migrant farmworker families from May through October each year. In 1995, data gathered by the Office of Migrant Housing in Sacramento, California, indicated that 70 percent of residents came to Art Ochoa from the desert Southwest. Therefore, this was an ideal location to interview farmworkers whose homebase was the research area.

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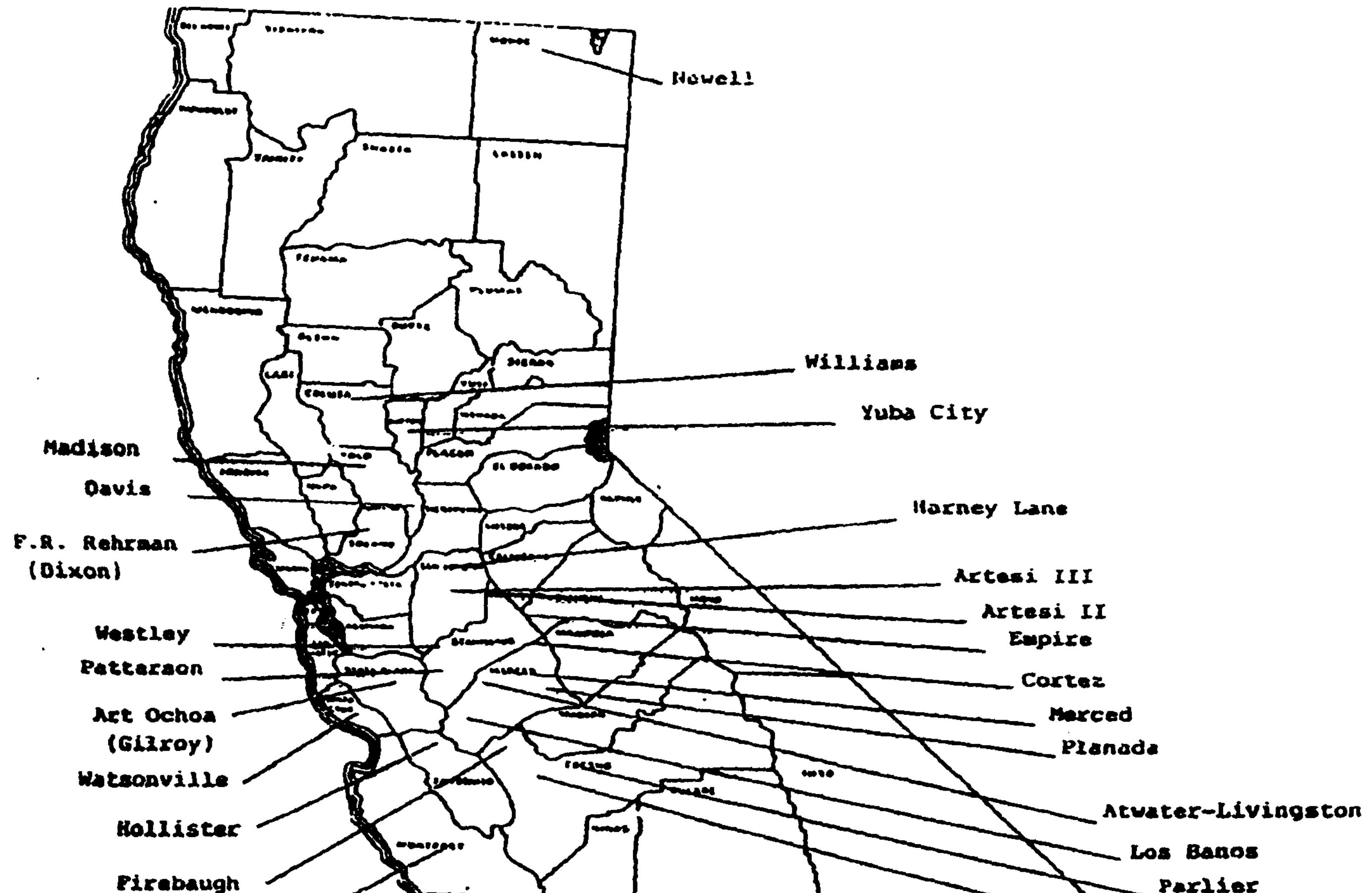
FIGURE 3.1

STATE MIGRANT FAMILY HOUSING CENTERS

Office of Migrant Services



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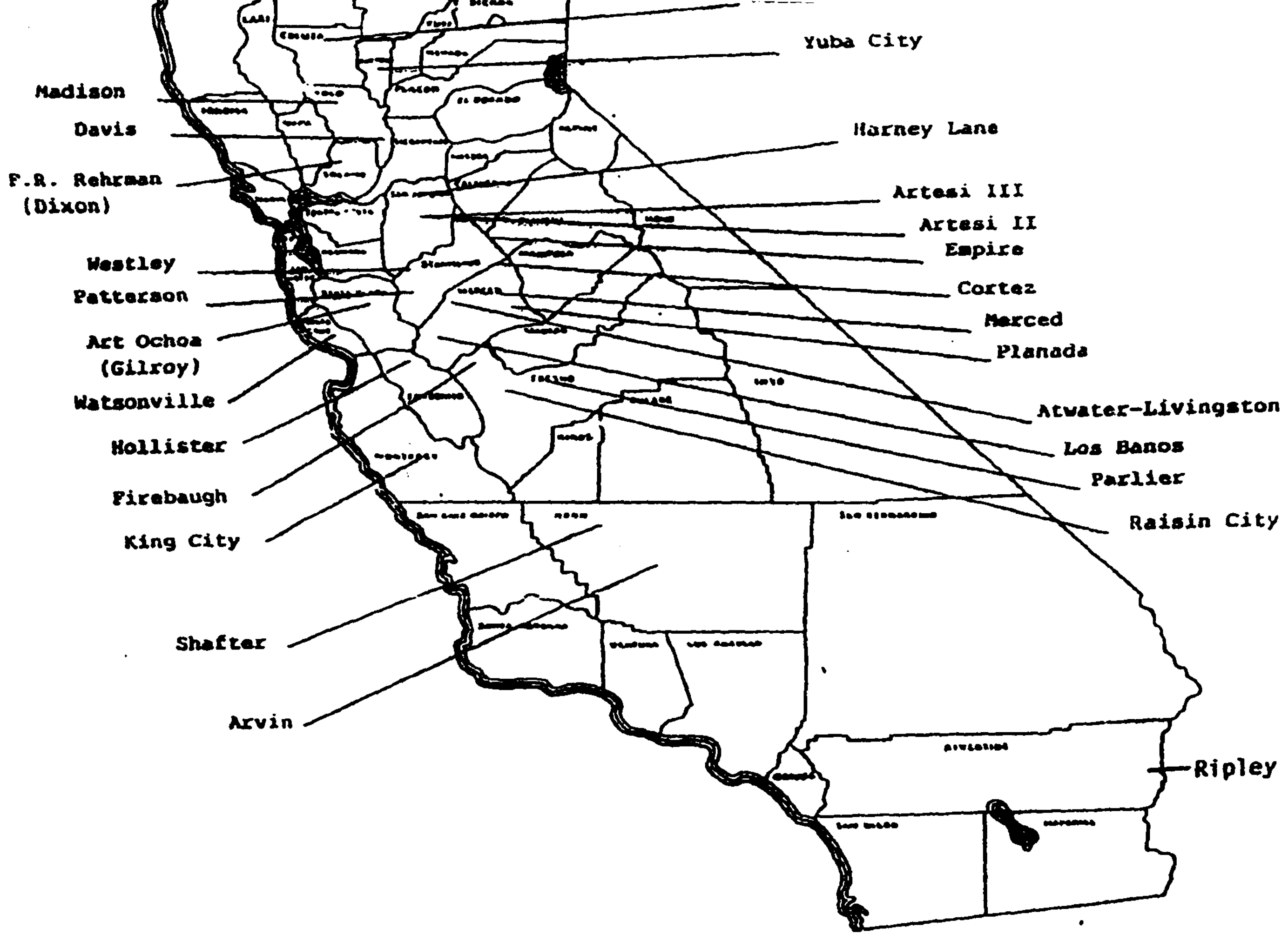

STATE OF CALIFORNIA - BUSINESS, TRANSPORTATION AND HOUSING AGENCY

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT

DIVISION OF COMMUNITY AFFAIRS

1800 THIRD STREET, SUITE 390
SACRAMENTO, CA 95814
P.O. BOX 952054
SACRAMENTO, CA 94252-2054
(916) 322-1560
FAX (916) 327-6660

From August 1996 through September 1996, 36 farmworker households were interviewed at the Art Ochoa Migrant Housing Center in Gilroy. Thirty-one of these interviews were included in the analysis for this study, which represents 32 percent of the dwelling units at the Art Ochoa Migrant Center. Interviewing farmworkers as they were living and working in an "upstream" location proved to be valuable because participants were able to give detailed responses on their experiences with medical services as they were living through it. The following briefly describes the homebase location.

Homebase: Mecca, California

From February 1997 through August 1998 and from April through June 1999, I interviewed, worked, and lived in Mecca. Mecca is located in the Colorado Desert in an unincorporated area of Southeastern Riverside County. Mecca is a one-hour drive north of Mexicali, Mexico. Overall, 99 Mecca farmworker households were included in the data analysis.

According to the 1990 census, Mecca is a homebase farmworker community of 1,966 residents. However, the population has more than doubled during the last nine years due to the completion of several hundred affordable housing units. Mecca health clinic personal, as well as the Mecca Community Council, and local law enforcement estimate the year-round population at around 5000 residents, most of whom are farmworkers. This unofficial estimate is based on the number of water meters serving Mecca residents. Mecca represents a unique research site since California resident farmworker families are concentrated geographically and the community is 95 percent Latino– 91 percent Mexican ancestry (1990 Census).

While residing in Mecca, I observed three agricultural cycles and the fluctuations in Mecca's population at both peak and low seasons. In Mecca, I interviewed both migrating and non-migrating farmworker families at six subsidized complexes where farmworkers live– Pie de la Cuesta, Nueva Vista, Paseo de las Poetas, Mecca 2, Thunderbird, and the Claire Johnson Units. Moreover, I also interviewed a small sub-sample of households living in trailer parks, as well as farmworker families living in private homes financed by Housing and Urban Development (HUD).

This brief description of the research sites provides the context for the following discussion of the data collection process. The discussion also includes sections on: the survey, definitions of agricultural workers, human subject protections, sampling, and recruitment of farmworker households.

Data Collection

In the first phase, from November 1994 through June 1996, interviews were conducted with 75 key informants. These included 19 academic researchers, 12 Community and Migrant Health Center staff, 11 farmworker advocates, three farmworkers, and four lawyers. I also conducted site visits of several Community and Migrant Health Centers throughout California. These semi-structured interviews and clinic visits pointed to key issues salient to farmworker health care access.

During the second phase, from August through September 1996, 36 farmworker households were interviewed at the Art Ochoa Migrant Housing Center in Gilroy. However, data from only 31 households was analyzed since five households were dropped because their homebase turned out to be a location other than the desert southwest. The survey instrument was also refined for its subsequent use among

farmworkers in Mecca.

The third phase of the research project, from February 1997 through August 1998, was the longest and most intense period of fieldwork. During this time, 100 farmworker family households, homebased in Mecca, were interviewed. Ninety-nine households can be used in the data analysis since it later turned out that one participant was not a farmworker. Transcription of taped interviews was also completed during this time.

For the duration of the fourth stage of this research project, from September 1998 through March 1999, I entered data from the survey instruments into two database programs, Microsoft Access in the Windows environment and My Advanced Database in the Macintosh environment. Simple descriptive statistical analysis was done in Microsoft Access, My Advanced Database, and SPSS.

For the fifth phase of this study, April 1999 through July 1999, I returned to Mecca to complete semi-structured qualitative interviews with key informants. From July through December 1999, this dissertation was written.

Survey

This section provides information on the survey questions. Most interviews with farmworker households took, on average, an hour and a half to finish. Questions guiding the ethnographic collection of qualitative data were aimed at understanding when, where, and under what circumstances farmworkers and their dependents solicited medical care. The main purpose of these in-depth interviews with farmworkers was to understand the relationships that they have with health care providers in their homebase residence and also when they migrate up north.

Data was collected on basic demographic factors, work histories, medical service experiences, and use of public services. More specifically, this survey asked farmworkers about their employers, where they work and travel for work, education levels, literacy, type of health coverage, use of Mexican medical services, the last time a family member used medical, dental, eye, chiropractic, pharmacy services, and their use of emergency medical services in the United States. Specific questions were asked on whether or not they were ever denied medical care in the last four years. Respondents also rated the quality of medical services and estimated how much they were willing to pay for specific medical services. In addition, information was solicited on the use of 117 medicinal teas and the use of traditional medical practitioners such as a "sobador" or a "partera." Data collected on the use of traditional medical practices provides key comparative information on the extent to which farmworkers rely on these methods of healing, even though most farmworker households in this sample lived less than a mile from the nearest primary health clinic.

Farmworkers were also asked to reveal the types of health problems their household members experience, their working conditions, and their use of public services such as unemployment insurance, food stamps, WIC, Cal-Works, etc. Information on documentation status of each household member was also obtained, as well as his or her opinions on the new legislation affecting immigrants. The full questionnaire is located in Appendix 1.

This type of data was collected in order to understand the process by which farmworkers and their dependents utilize medical services and other public programs. This research endeavor also sought to understand to what extent household members self

medicate or utilize traditional medical practices or both. Moreover, the survey instrument gave farmworkers the opportunity to voice their concerns about their medical needs, and the medical services designated for them, and their ability to pay for medical care. Due to time limitations, only parts of the data collected were analyzed for this dissertation manuscript.

Farmworker Households

Defining farmworker households was a critical methodological issue. This study focuses on farmworker families who lived primarily in subsidized housing. Excluded from this research were single migrant males, homeless farmworker families, and families in which all members of the household were undocumented. Households were selected if one or more members worked in agriculture during the 1995, 1996, 1997, or 1998 seasons. A farmworker household in this study was defined as a family unit living in the dwelling unit at the time of interview. The survey gathered data on each member of the farmworker household.

Sometimes I encountered more than one household living in one dwelling unit. Typically this meant that two or more families were living together. If both of these households qualified, I would ask both households to participate in the study. Furthermore, in the apartment complexes, occasionally one household that I interviewed moved out and another qualifying household moved into the same dwelling unit. Overall, two dwelling units contained six households interviewed for this research project. However, most households that participated in this study were comprised of simple nuclear families – parents and their children living together in one dwelling unit.

A household was designated as either migrating or non-migrating, depending on whether or not one or more household members traveled outside its homebase area for agricultural work during the last four seasons. A "migrating" work experience was defined as employment in agricultural labor in an area beyond Southeastern California (the geographic areas confined to the Imperial and Coachella Valleys). On the other hand, a "non-migrating" work experience was defined as employment of a farmworker who lived and worked within the confines of the Imperial and Coachella Valleys during the last four seasons. Therefore, in order to be designated as a migrating household, one or more farmworkers in the household had to have migrated within the last four years. Many types of migrating experiences were captured in the data collection process. Those interviewed in Gilroy described their experiences while living in the relatively comfortable Art Ochoa housing complex. Migrating farmworkers interviewed in Mecca, however, tended to live in poor quality housing conditions when they traveled North for agricultural work. It also needs to be pointed out that most farmworkers in non-migrating households had experience migrating prior to the 1994 agricultural season. However, they were designated as non-migrating households for purposes of this research if they had not migrated between 1995-1998.

Human Subject Protections

The issue of protection of participant privacy and confidentiality of research data was of prime importance. Research notes and survey forms have been coded to protect the subjects' identity. Other measures were taken to protect the participants from risk. For example, where and when interviews were conducted received careful consideration. Interviews were never conducted at work sites or at labor pick up locations in order not to

interfere with the job-hunting process. It is also important to note that in most studies involving human subjects, the researcher's Institutional Review Board requires the researcher to obtain written consent from each research participant. In this case, the Institutional Review Board at the University of California, Irvine, granted this research project a waiver of the written consent requirement after going through full committee review. I argued that written consent may have intimidated some potential participants since it leaves a record of who participated, and this could put subjects at risk if somehow my notes were ever stolen or lost. Overall, since participation in this study was voluntary and anonymous, risks to human subjects were not encountered.

Interview Techniques

Questions were designed to elicit farmworkers' experiences with medical services both when they migrated and when they worked at homebase. In both Mecca and Gilroy, I went door to door on foot. If a household agreed to participate, I obtained oral consent and a written and oral introduction was presented. This preliminary written introduction was in the form of a fact sheet and given to participants if they agreed to be interviewed. Figure 3.2 represents this informational fact sheet.

Figure 3.2: Fact Sheet

Acceso de Servicios Médicos entre los Trabajadores de Agricultura

Mi nombre es Katarina Azevedo. Soy una estudiante de ciencias sociales en la Universidad de California en Irvine y mis familiares fueron trabajadores del campo. Por eso tengo mucho interés en la salud de los trabajadores del campo. Este estudio es para entender sus opiniones sobre los servicios médicos que ustedes reciben en el estado de California. Antes de empezar, quiero decirle que yo no trabajo para el gobierno, ni para ninguna institución. Yo sólo me represento a mi misma. Las preguntas que voy a hacer son parte de mi trabajo de investigación académica y sus respuestas serán mantenidas en absoluta confidencialidad. Este trabajo de investigación está relacionado a mis estudios de antropología y medicina. Después de este estudio voy a dar un reporte a las clínicas y espero que esta información resulte en el mejoramiento de los servicios médicos que ustedes recibirán.

Access to Medical Services Among Farmworkers

My name is Kathryn Azevedo. I am a social science graduate student at the University of California at Irvine and my family members were farmworkers. For this reason, I have much interest in the health of farmworkers. This study is to understand your opinions about medical services that you receive in California. Before starting, I want to say that I do not work for the government or an institution. I represent myself. The questions that I am going to ask are part of my academic study. This study is related to my studies related to anthropology and medicine. After this study, I am going to give a report to the medical clinics. I hope that this information results in better medical services. Thank you very much for your participation.

Kathryn Azevedo, Ph.D. Candidate
University of California, Irvine
3151 Social Science Plaza
Departments of Anthropology and Sociology
Program in Social Relations
Irvine, CA 92697-5100

760 396 0811 telefono en Mecca
714 824 8444 telefono de oficina
Email: kazevedo@orion.oac.uci.edu

When verbal consent was obtained from a farmworker, the interview began, usually in the farmworker's dwelling unit. Sampling this vast but relatively hidden population was challenging. The following section describes this process.

<u>Sampling A Difficult Population</u>

Lepkowski, in his work on sampling the "difficult to sample" has asserted that migrant farmworkers are inadequately represented in national health surveys since a sampling frame has not been developed for this group. He recommends a non-probability sampling strategy (Lepkowski 1991). Stepick and Stepick assert that sample survey research among recent immigrant populations can be accomplished with the use of ethnographic anthropological methods (Stepick and Stepick 1990). In this study, the ethnographic approach began with in-depth semi-structured interviews of farmworkers, farmworker advocates, and medical care professionals. These discussions led to the development of a sampling strategy that, I believe, is representative of farmworkers homebased in the Coachella and Imperial Valleys of Southeastern California.

This population was difficult to sample because of three problems: 1) accurately determining who is a California-resident farmworker rather than a Mexican national; 2) distinguishing between migrant and non-migrating farmworker households; and 3) ultimately finding the California-resident migrating farmworker who was truly homebased in Southeastern California. It is valuable to differentiate the socio-political status of farmworkers since immigration status determines which type of public health services they can obtain at subsidized rates. Stepick and Stepick, in their survey research among Haitians in Miami, outlined the difficulties of obtaining this type of sample for survey research. These unique difficulties include "enumerating the population and

drawing a sample; constructing reliable questions that are sensitive to cultural differences; finding interviewers who can work with immigrants; and obtaining the cooperation from respondents" (Stepick and Stepick 1990). As a participant researcher, I addressed these issues by living in a homebase farmworker community for more than two years, learning about specific subsidized housing programs that farmworkers qualify for, conducting the interviews myself, and paying a great deal of attention to the research recruitment process.

More specifically, preliminary interviews provided the information needed to map the areas where most of the farmworkers lived. Mapping is a process used to determine where a hard to reach population may live. In Mecca, I focused on mapping permanent dwelling units that consisted of established subsidized housing units. In Gilroy, I mapped all the permanent dwelling units at the Art Ochoa Migrant Center.

I focused efforts on the subsidized apartment units since the head of household must prove to be legally present in the United States. As a consequence, this study primarily focused on California-resident farmworker households who would tend to qualify for some public benefits based on their low income and legal resident status.

Overall, I used non-probability sampling that yields what is known as a cluster sample (Bernard 1994). The clusters sampled were designated, subsidized, government housing units located in Santa Clara and Riverside counties. More specifically, I attempted to contact all families living in four out of the six housing complexes in Mecca and in the migrant-housing center in Gilroy. This is known as conducting a "census" of all the people living in chosen clusters. I also conducted a sub-sample of farmworker families living in trailers, HUD homes, and private apartments in Mecca. This is known

as convenience sampling. Despite the inherent weaknesses of this type of sampling strategy, I believe that farmworker households interviewed in this study are representative of farmworker family households homebased in Southeastern California. The sample process used, although not random, was systematic and at the very least the information gathered provides a firm foundation for future random, probability based research projects among farmworkers.

Other people important to the lives of farmworkers from this region were also interviewed. These include advocates, health care providers, local merchants, and politicians. Recruiting the farmworkers and those who interact with them to participate in this study required steadfast persistence.

Recruitment

Recruiting farmworkers living in the subsidized housing was complicated. I obtained permission to interview farmworkers at the temporary migrant housing centers in California by writing, phoning, and finally meeting officials representing the California Office of Migrant Services. Locally, at the migrant center in Gilroy, I introduced the study at the community resident meetings. At these meetings attendance was high because one member per household was required to attend or pay a fine. Usually around 80-100 residents were in attendance. At these meetings, the study was explained in Spanish and English in front of the residents. Therefore, most people knew I would be coming to knock on their doors to ask for an interview.

In Mecca, I introduced myself to all the apartment managers and received permission to knock on the doors of the apartments in the various complexes. I also introduced the project at two community council meetings and at two well-attended

school parent-teacher conferences held at the Mecca Elementary School. In Mecca, I went door to door, sometimes walking great distances to get an interview.

During the two years that I lived in Mecca, I tried to be visible to community members. I volunteered at the elementary school and at the Mecca Clinic and I was eventually trained as a community health worker for the Coachella Valley Health Care Connection. I also attended most Mecca Community Council Meetings, Health Start Meetings, and Mecca Health Council Meetings. In the evenings, I coached a girl's softball team.

Recruitment of health care providers and farmworker advocates was done by letter, followed by a telephone call, and a person-to-person meeting. Interviews were scheduled at their convenience.

It is also important to mention that the Mecca Clinic was located in the Nueva Vista Apartments where I lived. Due to the close proximity of the clinic, I was kept well informed of their medical services and of any special clinic workshops or outreach projects.

In short I lived, worked, and conducted research where a large concentration of farmworkers lived. Since I was without a car, I walked to local markets and the post office and took the bus when I needed to go into town. Therefore, I was very visible to most community members in this small town. This research methodology can be defined as community-based in that I solicited the help of both farmworkers and local farmworker advocates in the development of the survey, and I immersed myself in the environment where research participants lived. High visibility had a positive effect on recruiting research participants.

Data Analysis

Qualitative and quantitative data analysis procedures were employed. Analysis of the data included content analysis of taped narrative interviews and descriptive statistics generated from the survey data.

Essentially, when conducting content analysis I looked for common themes that emerged from the specific questions. Semi-structured, open-ended interviews resulted in qualitative, textual narrative data that were analyzed to draw out major themes. Riessman's work articulates the method on narrative analysis. Briefly stated, this process involves "telling," "transcribing," and "analyzing" (Riessman 1993). In practice, the first step involved interviewing the farmworkers in their home environment giving them farmworker and their family members the opportunity to "tell" their story. Some parts of the survey instrument were highly structured since several questions asked for specific discrete pieces on information. However, towards the end of the interview, several questions were more open-ended, giving the farmworkers a chance to open up and elaborate on their experiences, good and bad, with health care providers in the United States and Mexico. To facilitate recall, I used two visual aids. The first aid consisted of the survey instrument itself. Since some of the farmworkers interviewed were literate, I encouraged them to see and read the survey giving them the chance to ask further questions. Upon reading the survey, which was in Spanish and English, the farmworkers saw how it was coded and could feel assured that their identity would be protected. A second visual aid was used during the section of the survey that inquired about the use of traditional or homemade remedies. This visual aid consisted of a binder with pictures of approximately 117 herbs that are readily available in most small markets and grocery

stores used by Spanish speakers and Native Americans in the desert Southwest. This aid facilitated recall and allowed for detailed descriptions of how and when a particular herbal remedy was used. Prior ethnographic research that I had done indicated that many people from Mexico often use an herbal remedy before seeking medical attention. Ensuing conversations with farmworkers dovetailed nicely into subsequent questions about their experiences with medical providers.

Another aid used during the interview process consisted of a small tape recorder. I obtained permission from 44 households (34 percent) to tape portions of the interview. After these interviews were taped, the tapes were transcribed verbatim. This produced approximately 300 pages of transcribed research material in Spanish. Transcription, according to Riessman, cannot be easily distinguished from the analysis stage. She goes on to state that, "close and repeated 'listening', coupled with methodic transcribing, often leads to insights that in turn shape how we choose to represent an interview narrative in our text" (Riessman 1993). The transcription process took almost a year to complete.

But once a researcher has pages and pages of written material, another process of data reduction and interpretation must transpire. Interpretation, in this case, required translation from Spanish to English and thus special attention to the nuances of the regional Spanish spoken in these areas of California. Some passages are more difficult to interpret than others because the meaning is sometimes lost when translating from Spanish to English. In these cases, I asked for assistance from bilingual students and professionals. After transcription and translation, I analyzed this narrative data by dividing the textual passages into 38 major themes. I then proceeded to organize portions of them into the following chapters. In summary, the more qualitative aspects of the data

analysis process require a great attention to detail and a realization that the process of interpretation has its limitations. However, as Riessman points out, "ultimately, of course, the features of an informant's narrative account an investigator chooses to write about are linked to the evolving research question, theoretical/epistemological positions the investigator values, and more often than not, her personal biography" (Riessman 1993). Despite these possible biases, narrative analysis generated from taped interviews still provides research participants, in this case farmworkers, a real opportunity to tell their experiences in their own words. Nevertheless, this was not the only type of data analysis done for this research project.

Simple descriptive statistics were generated from the farmworker survey instruments. The data were entered into two database management programs– Microsoft Access in the Windows environment and MyAdvanced Database in the Macintosh computer environment. Later, I transferred the data into SPSS, a statistical software program in the Windows environment.

In addition to the survey data and formal interviews, I collected, through informal methods, 11 hardbound volumes of field notes, totaling more than 4000 pages of handwritten notes. These field notes include minutes of meetings attended, daily descriptions of what it is like to live in Mecca, receipts, hand drawn maps, etc. Moreover, I took more than 600 photographs and slides of farmworkers and their families in their homes, schools, town events, and even the fields where grapes were harvested. I obtained oral consent from every person photographed and I made duplicates of the photos and gave them to participants if I could find them. Furthermore, I conducted archival research at the Mecca Public Library and at Imperial County Community College in

order to get historical accounts of the region.

My fieldwork synthesizes of all these cumulative research experiences. Living and working in both field sites over several years allowed me to put survey data in a fuller and more informed sociocultural context. By combining participant observation and systematic data collection by means of the survey, I was able to use the strengths of each method to overcome their inherent weaknesses.

The following chapter elaborates on the basic demographic characteristics of these California farmworker households.

CHAPTER 4: DEMOGRAPHICS

This chapter elaborates on the basic demographic features and employment patterns of members of farmworker households in this sample.

Household Sample

Data was collected on 560 people living in 130 households– 238 adults and 322 dependents under the age of 18. Of the 238 adults, 180 identified themselves as full-time farmworkers– 75 women and 105 men.

First, it is important to describe the breakdown between migrating and non-migrating farmworker households. Table 4.1 describes the household sample by locations and migration status.

TABLE 4.1
FARMWORKER HOUSEHOLD SAMPLE

Field Location	MIGRATING HOUSEHOLDS	NON-MIGRATING HOUSEHOLDS	TOTAL HOUSEHOLDS
Gilroy, CA	30	1	31
Mecca, CA	44	55	99
TOTAL	74	56	130

Source: Kathryn Azevedo Dissertation 2000

Farmworker households residing in several types of dwelling units were interviewed. In Northern California, 31 households from the Art Ochoa Migrant Family Housing Center in Gilroy, CA, were interviewed. In Southern California, 99 households from Mecca, CA, participated in this study. In Mecca, 64 households came from six different subsidized government rental units and 35 households from other types of dwelling units: eight households from privately rented apartments, 12 households in trailers, and 15 from homes financed by Housing and Urban Development (HUD) funds.

An approximate estimate of the percentage of farmworker households sampled in subsidized rental housing units was made as follows. On July 14, 1998, during peak season, I asked each apartment manager in the subsidized units in Mecca to calculate the exact number of households who had at least one adult member employed as a farmworker for at least nine months. The results are in Table 4.2.

TABLE 4.2 HOUSING UNIT SAMPLE		
	Apartment Data	**Actual Sample Obtained**
Claire Johnson	20/40	17/20
Nueva Vista	17/32	20/17 *
Paseo de las Poetas	9/21	9/9
Pie de la Cuesta	60/68	16/60
Mecca 2	20/60	1/20
Thunderbird	16/54	1/16
TOTAL	142/275 51.6% were farmworker households	64/142 45% of all farmworker households were interviewed

Source: Kathryn Azevedo Dissertation 2000

As of July 1998, there were 275 low-income government-subsidized rental dwelling units in Mecca. On July 14, 1998, 142 of these households had one or more adult members listed as working for at least nine months in agriculture. I interviewed 64 out of these 142 households. Therefore, I interviewed approximately 45 percent of the farmworker households living in subsidized housing Mecca, CA. This is only an approximate estimate since the number of farmworkers living in these units varies by month. However, since I made the estimate during peak season, May through July, more farmworker households were present than at other times during the year. It must be noted that when a household moved out of an apartment, I would introduce the study to the new

residents. If they qualified, I would also interview this new household in the same apartment dwelling. This happened in the Nueva Vista apartment complex. This explains why 20 households were interviewed. I only obtained one household from the Thunderbird complex because fewer households qualified and it was more difficult to reach geographically. This approximation is useful because it is often assumed that only farmworkers live in these subsidized units. As I went door to door it became apparent that a variety of low-income households resided in these units. Neighbors of farmworker households living in these subsidized units included construction workers, gardeners, nurses' aides, day care workers, teacher's aides, mechanics, and grocery store personnel. It is interesting to note that many people started out as farmworkers but changed their career trajectory when given the opportunity.

Overall, interviewees lived in 130 separate households. One-hundred-thirty of these households had at least one female adult, 108 of these households had at least one male adult, and 126 households reported a total of 322 children under the age of 18 living in the dwelling unit. Next I discuss the birthplace of these household members.

TABLE 4.3 BIRTHPLACE: FEMALE			
	NON-MIGRATING N=55	**MIGRATING N=75**	**TOTAL N=130**
MEXICO	50 89.0%	67 90.5%	117 90.0%
UNITED STATES	5 9.0%	8 11.0%	13 10.0%

TABLE 4.4 BIRTHPLACE: MALE			
	NON-MIGRATING N=41	**MIGRATING N=67**	**TOTAL N=108**
MEXICO	40 97.5%	62 92.5%	102 94.4%
UNITED STATES	1 2.4%	4 5.9%	5 4.6%
EL SALVADOR	0.0%	1 1.4%	1 0.9%

TABLE 4.5 BIRTHPLACE: CHILDREN OF FARMWORKERS			
	NON-MIGRATING N=123	**MIGRATING N=199**	**TOTAL N=322**
MEXICO	45 36.6%	52 26.1%	97 30.1%
UNITED STATES	78 63.4%	147 73.9%	225 69.9%

Source: Kathryn Azevedo Dissertation 2000

Birthplace

Table 4.3, Table 4.4, and Table 4.5, illustrate where members of farmworker households were born. These tables indicate, more than 90 percent of the adult women and men were born in Mexico. Seventy percent of the 322 children under 18 living in the household were born in the United States whereas 30 percent of the children were born in Mexico. In 26 out of the 126 households reporting children under the age of 18, some of the older children were born in Mexico while the younger children were born in the United States. Therefore, in a given household some members could be Mexican Nationals while other members could be American citizens. This creates what Leo Chavez calls a "binational family" (Chavez 1992). Differences in birthplace lead to differences in legal status. The concept of a binational household gains importance later when I examine the legal status of members of farmworker households.

Legal Status

Birthplace is closely related to socio-political status. Citizenship often determines what types of programs that this low-income group can qualify for. As a whole, most adult farmworkers in this sample were legal immigrants while children of farmworkers were most likely to be American citizens. However, this research also reveals that 20 percent of the women were undocumented even though they were married to a man who was a legal immigrant or US citizen. Table 4.6, Table 4.7, and Table 4.8 below examine these trends in greater detail.

TABLE 4.6 LEGAL STATUS: FEMALE			
	NON-MIGRATING N=55	MIGRATING N=75	TOTAL N=130
AMERICAN CITIZEN	7 12.7%	12 16.0%	19 14.6%
LEGAL RESIDENT	35 63.6%	50 66.6%	85 65.3%
UNDOCUMENTED	13 23.6%	13 17.3%	26 20.0%
UNKNOWN	0%	0%	0%

TABLE 4.7 LEGAL STATUS: MALE			
	NON-MIGRATING N=41	MIGRATING N=67	TOTAL N=108
AMERICAN CITIZEN	7 17.0%	7 10.4%	14 12.9%
LEGAL RESIDENT	29 70.7%	54 80.5%	83 76.8%
UNDOCUMENTED	4 9.7%	3 4.4%	7 6.4%
UNKNOWN	1 2.4%	3 4.4%	4 3.7%

TABLE 4.8 LEGAL STATUS: CHILDREN			
	NON-MIGRATING N=123	MIGRATING N=199	TOTAL N=322
AMERICAN CITIZEN	78 63.4%	147 73.9%	225 69.9%
LEGAL RESIDENT	31 25.2%	35 17.6%	66 20.5%
UNDOCUMENTED	14 11.4%	17 8.5%	31 9.6%

Source: Kathryn Azevedo Dissertation 2000

Among the adults, close to 80 percent of the women in this sample were legally present in the United States due to their status as legal resident or an American citizen. Among both the men and children, 90 percent were legally present in the United States due to their status as a legal resident or an American citizen. These high percentages of persons legally present in the United States reflect the reality that the head of household in government subsidized rental units must be documented. Despite the fact that the head of household was legally present in the United States, other immediate family members may not be. Another goal of this research was to understand the effect of legal status on health care access since these binational households face unique dilemmas when trying to access medical services. Subsequent chapters will present these issues in greater depth.

Civil Status

TABLE 4.9
CIVIL STATUS OF HEAD OF HOUSEHOLD

	NON-MIGRATING N=55	MIGRATING N=75	TOTAL N=130
Married	61.8% 34	80.0% 60	72.3% 94
Single	20.0% 11	8.0% 6	13.1% 17
Single: Living Together	9.0% 5	8.0% 6	8.5% 11
Divorced	1.8% 1	0% 0	.8% 1
Separated	7.2% 4	1.3% 1	3.8% 5
Widowed	0% 0	2.6% 2	1.5% 2

Source: Kathryn Azevedo Dissertation 2000

At this point it is useful to examine the civil status of heads of household. The civil status of couples may influence the type of medical insurance that members of farmworker households qualify for. Marriage, for example, may provide the opportunity

for medical insurance for spouses and dependents if one of the adults has employment-based medical insurance. Moreover, a single mother may be more likely to qualify for public medical insurance. The specific relationships that civil status may have on medical insurance coverage will be discussed in later chapters.

Table 4.9 above presents findings on marital status. It illustrates that 72 percent of all farmworker households interviewed contained a married couple. Eighty percent of the migrating households had a married couple, whereas 62 percent of the non-migrating households had a married couple. In comparison with non-migrating households, migrating households were more likely to contain a married couple. Moreover, eight percent of migrating and nine percent of non-migrating households contain couples who were single but live together. Twelve out of 17 households can be defined as single-parent households in which one parent cared for at least one child under 18; all 12 contained female heads of household. Only one head of household in this sample reported that she was divorced.

Another way to examine this data is to collapse the civil status categories into two divisions– farmworkers living with a partner, whether married or not, versus heads of household living without a partner. A chi-square analysis was run on the two divisions of civil status and the results are as presented in Figure 4.1. Examining the statistical relationship between civil status and migration is important because it provides one way to reinforce the distinctions between migrating and non-migrating farmworker households that ultimately impact access to medical services.

FIGURE 4.1 Chi-Square Analyses of Civil Status and Migration

Farmworkers Living with Partner * Migration Crosstabulation

			Migration		Total
			m	nm	
Farmworker Living with Partner	alone	Count	9	16	25
	partner	Count	66	39	105
Total		Count	75	55	130

Chi-Square Tests

	Value	df	p < .025
Pearson Chi-Square	5.967	1	

Source: Kathryn Azevedo Dissertation 2000

When collapsing the two categories of civil status into "living alone" and "living with a partner," nine migrating heads of household reported living alone and 66 reported living with a partner. For non-migrating heads of household, 16 lived alone while 39 lived with a partner. The chi-square test was used to evaluate the relationship between these two nominal variables because assumptions about the normal distribution of this population could not be met (Bernard 1994; Voelker and Orton 1993). A chi-square test of independence was calculated comparing migration with heads of household living alone versus those living with a partner. A significant interaction was found: chi-square (1) = 5.967, $p < .025$. Therefore, heads of household in migrating farmworkers are more likely to live with a partner than are heads of households in non-migrating farmworkers. In summary, it appears that at alpha .05, a chi-square value of 5.967 with 1 degree of freedom, there is a mildly significant relationship between partnership and migration status. This would suggest that in this sample, the tendency that migrating households

were more likely to contain couples living together than were non-migrating households is statistically significant.

This finding is important since a farmworker living with his or her partner has certain advantages. For example, couples living together, whether married or not, may have larger incomes and more social networks; at least one of the adults may have employer-based medical insurance; and there may be more relatives who could assist the family financially in a medical emergency. Therefore, partnership and migration patterns may indirectly influence medical insurance coverage and consequently the use of medical services for members of farmworker households. I will explore these findings in greater detail in subsequent chapters.

Average Ages of Adults

It is also worthy the time to examine the average ages of the adults in this sample. Table 4.10 illustrates that there is little difference in ages between migrating and non-migrating households. As explained earlier, information was gathered on 238 adults–farmworkers and their spouses. Age data, however, is missing for 23 people for this analysis so the total number of adults for whom there is age data is 215. Some farmworkers did not want to reveal their ages, and some did not know the age of their partner, if that partner was not present at the interview.

TABLE 4.10 AVERAGE AGES OF ADULTS			
	NON-MIGRATING (54Women+ 57 Men) = N=111adults	MIGRATING (72 Women+32Men) N=104 adults	TOTAL* 215 adults
FEMALE N=126	35.42	35.14	35.26
MALE N= 89	40.47	37.81	38.76

Source: Kathryn Azevedo Dissertation 2000

The average age of women, in both migrating and non-migrating households, was 35 years. The average age of migrating men was 38 years, and the average age of non-migrating men was 40 years. The total average ages of adults in this sample lie in a range between 35 and 40 years old, indicating that the farmworkers interviewed were relatively young and were very likely to be supporting children under 18. The following section goes into greater depth on children residing in farmworker households.

Number of Children in Farmworker Households

The average number of children in a farmworker household suggests the extent of the family's financial responsibility. Table 4.11 illustrates findings on the average number of children in both migrating and non-migrating households: each type of household had close to four children.

TABLE 4.11 AVERAGE NUMBER OF KIDS PER HOUSEHOLD			
	NON-MIGRATING N=52 households	MIGRATING N=74 households	TOTAL N=126 households
Number of Kids < 18 years N= 322	3.92	3.68	3.77

Source: Kathryn Azevedo Dissertation 2000

As stated earlier, data was collected on 560 people living in 130 households– 238 adults and 322 dependents under the age of 18. It is important to point out, however, that many households identified adult children as part of their household even if they were not living with them. For example, 26 households reported having dependents living in the United States between 18-20 years of age, while 23 households reported having adult children 21 and over. One-hundred-twenty-six heads of households in this studied actually reported having a total of 467 children. Three-hundred-twenty-two of these children were under 18 years of age and living in the household at the time of the interview. Figure 4.2 provides more detail on the range of the number of children reported by heads of farmworker households. Figure 4.2 illustrates that the majority of households had four or fewer children.

Figure 4.2: Children Per Household

Number of children per Household	Number of households	Total Children
0	4	0
1	17	17
2	24	48
3	23	69
4	28	112
5	15	75
6	4	24
7	5	35
8	6	48
9	1	9
10	3	30
	Total:	467

Source: Kathryn Azevedo Dissertation 2000

Ages of Children in Farmworker Households

Farmworker households in this sample were typically financially responsible for children who range in age from very young to adolescents. Table 4.12 reveals the distribution in ages for children living in migrating (M) and non-migrating (NM) farmworker households.

Table 4.12: Ages of Children in Farmworker Households

Age of Child	Migration Status		Count
	M	NM	Total
1	23	7	30
2	13	5	18
3	8	11	19
4	19	10	29
5	17	7	24
6	11	10	21
7	7	8	15
8	12	9	21
9	10	2	12
10	9	5	14
11	13	8	21
12	9	9	18
13	10	4	14
14	14	10	24
15	8	10	18
16	7	4	11
17	9	4	13
Total	199	123	322

Source: Kathryn Azevedo Dissertation 2000

The average age for children in both groups was 8.0 years. For migrating households, the average age was 7.97 years, and the average age for children in non-migrating households was 8.3 years. Migrating households were more likely to report children who were younger than children from non-migrating households.

It is important to point out that the greater the number of children per household, the greater the need for medical services and access to these services. Furthermore, the medical needs of children in farmworker households change as they grow. Infants and small children usually need prompt medical attention for sudden infectious diseases, while adolescents often need medical services for injuries related to accidents. Qualitative data also indicates that children in this sample, especially girls ages 14 through 17, sometimes need medical attention for reproductive services. Knowing the number of children per household and the ages of these children helps us gain an understanding about the medical needs and subsequent access issues that may arise for a given farmworker household.

Education of Adult Members in Farmworker Households

Information about the education levels attained by adults living in farmworker households is also relevant to understanding their access to medical services. Tables 4.13 and 4.14 represent the educational level of the adult women and men residing in farmworker households. Overall, the majority of men and women farmworkers in this sample had at least some grammar school education. Migrating women had more education than migrating men. Only two people in this sample went to high school in the United States. Otherwise the data represent education received in Mexico.

TABLE 4.13 LEVEL OF EDUCATION ATTAINED BY WOMEN						
	NON-MIGRATING N=55		MIGRATING N=75		TOTAL N=130	
NO EDUCATION	4	7.2%	3	4.0%	7	5.3%
GRAMMAR SCHOOL (1-6 YEARS)	30	54.5%	33	44.0%	63	48.5%
JR HIGH (7-9 YEARS)	12	21.8%	14	18.6%	26	20.0%
HIGH SCHOOL (10-12 YEARS)	4	7.2%	7	9.35%	11	8.4%
JR COLLEGE (1-2 YEARS)	3	5.4%	5	6.6%	8	6.2%
UNIVERSITY (3-5 YEARS)	0	0.0%	5	6.6%	4	3.0%
POST GRADUATE	0	0.0%	0	0.0%	1	0.7%
UNKNOWN	2	3.6%	8	10.6%	10	7.6%
TOTAL Σ	Σ 55	100.0%	Σ 75	100.0%	Σ 130	100.0%

Source: Kathryn Azevedo Dissertation 2000

TABLE 4.14 LEVEL OF EDUCATION ATTAINED BY MEN			
	NON-MIGRATING N=41	MIGRATING N=67	TOTAL N=108
NO EDUCATION	1 2.4%	2 2.9%	3 2.7%
GRAMMAR SCHOOL (1-6 YEARS)	19 46.3%	17 25.3%	36 33.3%
JR HIGH (7-9 YEARS)	7 17.0%	9 13.4%	16 14.8%
HIGH SCHOOL (10-12 YEARS)	2 4.8%	5 7.4%	7 6.4%
JR COLLEGE (1-2 YEARS)	0 0.0%	3 4.4%	3 2.7%
UNIVERSITY (3-5 YEARS)	1 2.4%	2 2.9%	3 2.7%
POST GRADUATE	0 0.0%	0 0.0%	0 0.0%
UNKNOWN	11 26.8%	29 43.2%	40 37.0%
TOTAL Σ	Σ 41 100.0%	Σ 67 100.0%	Σ 108 100.0%

Source: Kathryn Azevedo Dissertation 2000

The percentages obtained in this sample are similar to those reported in other farmworker studies (Guendelman 1991; Kerr and Ritchey 1990; Runyan 1992). The levels of education for both men and women and between migrating and non-migrating farmworkers reveal that most research participants had less than a high school education.

More specifically, 22.5 percent of migrating women and 14.7 percent of migrating men had attained a high school education or beyond, whereas only 12.6 percent of non-migrating women and 7.2 percent of non-migrating men had attained a high school education or beyond.

In order to examine this distinction further, a chi-square test of independence was calculated comparing levels of education and migration status for both adult men and women in this sample. Even dropping the missing cases and collapsing the educational levels into four categories, no significant statistical relationship was found between educational level and migration status for either men (chi-square (3) = 2.674, $p > .05$) or women (chi-square (3) = .916, $p > .05$).

Even though I cannot statistically support the qualitative observation that adults in migrating households have more education than the adults living in non-migrating households, this research still illustrates that some migrating farmworkers have indeed obtained significant levels of formal education in Mexico. For example, eight migrating farmworkers in this sample had at least two years of university level education. One of the eight migrating farmworkers even had a master's degree in education. On the contrary, none of the non-migrating farmworkers had at least two years of university education. I now turn your attention to the employment characteristics of farmworker households.

Employment Characteristics of Farmworker Households

It is engaging to examine further the division between adult farmworkers and non-farmworker spouses. To clarify further, there were 130 woman and 108 men on whom data were collected. Of the 130 women, 62 were employed farmworkers, 13 were

unemployed farmworkers, seven worked in other occupations, and the remaining 48 identified themselves as full-time homemakers. Of the 108 men included in this sample, 94 were farmworkers, 11 were unemployed farmworkers, one man worked in another occupation, and of those who remained one was retired, and one was disabled. In summary, of the 238 adults in this sample, 180 were farmworkers.

Companies and Contractors

Farmworkers in this study worked for many companies, most of which were relatively small companies. Some companies listed below are no longer in existence due to closures or mergers. The following Figure 4.3 highlights the companies at which research participants stated that they worked.

Figure 4.3 Companies Employing Farmworkers in the Study

Adobe Packing
Alco Packing
Amazing Coachella

Bell Farms
Borello Farms
Bruce Church
Bud of California

Cardinal
Chester Enterprise
Christopher Ranch
Coachella Valley Citrus
Cocopa Dates
Crown Hill

Desert Fresh
Dimara
Dole Fresh

Escamilo & Sons
Fever Ranch
Fresh Express
Golden Acre

Imperial Western

Jorge Ochoa Farms
K & W Farms
Kitagawa & Sons
Levimarra Vineyards

Mission Packing
Mona

Omar
Oscar Ortega

Pan American

Rancho American
Richard Bagdasarian
Ripaul Sorting
Rivera

Sam World
Sawyer American
Sea Son
Sierra
Silver Canyon Farming
Sojaras
Sonora Packing
Sun Date

Sunshine
Sun World

Tanin Murantle
Tudor

Valley Pride
Vege Pack
Venus Ranch

Zepeda Labor Contracting
6 Estrellas

Source: Kathryn Azevedo Dissertation 2000

Figure 4.4 illustrates the variety of field jobs at which farmworkers in this study were employed.

Figure 4.4: Field Jobs Worked by Farmworkers in this Study

Crop	Number of Laborers
Alfalfa	1
Almonds	1
Artichokes	1
Asparagus	5
Broccoli	11
Pumpkin	2
Carrots	1
Cauliflower	4
Celery	3
Citrus (Oranges, Grapefruit, Lemons)	33
Corn	8
Cotton	1
Cherry	3
Chile	28
Cilantro	1
Cucumber	3
Dates	4
Dried Fruit	4
Figs	2
Flowers	1
Garlic	8
Grapes	83
Green Beans	5
Green Vegetables	7
Lettuce	41
Onion	9
Melons	6
Peaches	1
Pears	1
Pumpkin	2
Spinach	4
Strawberry	2
Tomato	8
Wheat	1
Zucchini	1
Other Field Jobs	
Agricultural Machinery	4
Inventory	1
Irrigation	1
Sprayer	1

Kathryn Azevedo Dissertation 2000

Figure 4.4 demonstrates that most research participants were in fact those who worked directly with the crops in the fields or in the produce packinghouses. Only a few farmworkers in the sample had higher skilled, better paying jobs that included working with agricultural machinery, irrigation, or spraying pesticides. Overall, most research participants in this study worked with grapes, citrus, lettuce, and chile. The majority of farmworkers were involved in the harvest of two or more crops for more than one company. More specifically, only 44 out of 180 (24 percent) of farmworkers worked exclusively for one company year round. Multiple employment means less consistency in employer-based medical insurance. This issue will be examined in subsequent chapters.

There were also subtle differences in the types of crops that migrating farmworkers worked with compared to non-migrating farmworkers. *Migrating farmworkers,* who were interviewed in Art Ochoa, were more likely to work with lettuce. More specifically, 27 out of 31 or 87 percent of farmworker households had one or more members participating in the lettuce production. Migrating farmworkers homebased in Mecca were more likely to be involved in the grape harvest– 37 out of 44 households. This means that 84 percent of the migrating farmworkers interviewed and homebased in Mecca were involved in some aspect of the grape production.

Of the 55 *non-migrating* farmworker households homebased in Mecca, 40 out of 55 (72 percent) were involved in grapes, 17 out of 55 (31 percent) harvested citrus, and two out of 55 (3 percent) participated in both harvests. Nevertheless, one non-migrating farmworker family, interviewed in Art Ochoa, was involved in cherry, garlic, chile, tomato, and dried fruit harvests.

Most adult members of farmworker households in this sample were engaged in full-time agricultural labor for at least nine months of the year. Tables 4.15 and 4.16 summarize the hours and the number of years worked.

TABLE 4.15
AVERAGE HOURS PER WEEK WORKING IN AGRICULTURE

	TOTAL	MIGRATING	NON-MIGRATING
Male N=105	43.81	43.42	44.47
Female N=75	39.06	40.16	37.90

Kathryn Azevedo Dissertation 2000

In this sample, migrating and non-migrating farmworkers on average worked full-time at least 40 hours per week. The only notable difference was that women work slightly fewer hours than men. Based on participant researcher observation, women must fit work in with childcare and household responsibilities. This trend was also reflected in Table 4.16, which describes the average number of years in agriculture.

TABLE 4.16
AVERAGE NUMBER YEARS IN AGRICULTURE

	TOTAL	MIGRATING	NON-MIGRATING
Male N=105	14.75	13.6	16.78
Female N=75	8.69	8.90	8.46

Kathryn Azevedo Dissertation 2000

Overall, men worked more years in agriculture, whether they were migrating or non-migrating. Non-migrating men in this sample showed the greatest average number of years working in agriculture. Women showed fewer years participating in the agricultural workforce, reflecting the reality that, in the absence of day care, some women stay at home until their children reach school age.

Income Sources

Total income levels among farmworkers are often underestimated because other sources of income besides salaries are not considered. Tables 4.17, 4.18, and 4.19 include self-reported data on average monthly salary, unemployment compensation, AFDC/TANF (welfare checks), WIC coupons, and food stamps. More specifically, I asked farmworkers to estimate the monthly income of their household at the time of the interview. The average monthly household income from salaried employment for all farmworker households in this sample was approximately $1350.00 per month. Overall in the sample, migrating farmworkers earned more per month than non-migrating farmworkers.

TABLE 4.17
REPORTED MONTHLY INCOME FROM SALARIED EMPLOYMENT

	TOTAL	MIGRATING	NON-MIGRATING
Average Monthly Salary	$1350.00	$1470.00	$1185.00

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It is important to point out that this average monthly estimate of income from salaried work often included more than one salary pooled together. Table 4.18 on the next page illustrates unemployment income reported by farmworker households. Overall, 60 percent of farmworker households reported receiving unemployment within the 12 months prior to the interview.

TABLE 4.18 UNEMPLOYMENT COMPENSATION INCOME REPORTED BY FARMWORKERS			
	TOTAL	MIGRATING	NON-MIGRATING
Unemployment Compensation	60.0% $310.62	66.0% $290.26	59.0% $343.71

Kathryn Azevedo Dissertation 2000

Migrating farmworker households (66 percent) in this sample were slightly more likely to report receiving unemployment income than non-migrating households (59 percent). The relatively moderate use of unemployment compensation by both groups of farmworker households may be explained by the possibility that these households had more knowledge about how to utilize the services offered by the EDD (Employment Development Department) in California. EDD community workers, EDD advertisements in the Spanish news media, and farmworkers themselves aggressively disseminated information about EDD services. Table 4.19 illustrates the use of public assistance by members of farmworker households.

TABLE 4.19 USE OF PUBLIC SERVICES REPORTED BY FARMWORKER HOUSEHOLDS			
	TOTAL	MIGRATING	NON-MIGRATING
AFDC/TANF	9.16% $394.25	6.0% $425.33	9.0% $375.60
WIC Coupons	34.5% (38/110)	34.7% (24/69)	34.1% (14/41)
Food Stamps 1997	22.1% (29/130)	20.0% (15/75)	25.0% (14/56)

Kathryn Azevedo Dissertation 2000

Overall, the use of public assistance in the form of welfare checks (AFDC/TANF), WIC coupons, and food stamps was relatively low. Less than 10 percent of all farmworkers households reported receiving welfare checks within 12 months prior

to the interview date. Approximately 34 percent of the families received WIC food coupons, and approximately 20 percent of the households reported receiving food stamps, even though many more would qualify for these programs based on income levels for their household size.

It is important to point out, however, that this self-reported data is still probably an underestimate of total income received in a given month. For example, farmworkers also earn additional income by renting out a room or sofa;, re-selling jewelry, medicine, and other items purchased in Mexico; babysitting; making floral arrangements; and working for commission for cosmetic companies like Mary Kay and Avon. If a farmworker is literate in English, he or she may charge for helping a neighbor fill out forms. Some farmworkers also earn extra income by fixing appliances or cars on the side. If a farmworker has a car, he or she may charge for a ride. During periods when they receive unemployment compensation, some will work for cash by doing gardening or making garbage runs to the dump for those who own homes. Some women will make tamales, tortillas, and other food items and sell them to their neighbors. There was and continues to be a huge underground and unrecorded informal economy in both Mecca and Art Ochoa. For example, when I was taking photos of grape harvesters in the field I noticed two women farmworkers selling jewelry and one farmworker passing out catalogs for Mary Kay Cosmetics as they were pruning grapes.

Summary

As a whole, 73 percent of the farmworker households interviewed had a married couple. Households on the average reported close to four children and more than 90 percent of the adults were born in Mexico. At least 80 percent of adults and 90 percent of

the children living in farmworker households were legally present in the United States; at least 60 percent of men and 87 percent of women had some formal schooling; and the majority of farmworkers interviewed worked in the grape, citrus, lettuce, and chile harvests.

This concludes the demographic profile of the sample of farmworkers interviewed. The following chapter focuses on the lifestyle, work, and health profiles of migrating and non-migrating farmworker households sampled in this research.

CHAPTER 5: FARMWORKER LIFESTYLE, WORK, AND HEALTH

This chapter provides an ethnographic description of the lifestyles of the migrating and non-migrating farmworker households sampled in this study. First, migrant life is described at the Art Ochoa Migrant Family Housing Center in Gilroy, CA. Next, the lives of farmworker households interviewed at the homebase location, in Mecca, CA are examined. This is followed by looking at the work and health conditions experienced by members of these farmworker households. Incorporated throughout this chapter are interview passages from farmworkers and their advocates, some of which were translated from Spanish to English. Their articulate explanations greatly enhance our understanding of their lives, struggles, and triumphs. The original Spanish transcriptions are available in Appendix 2. The real names of the geographical locations, organizations, and the housing complexes were used. Nevertheless, in the interview passages throughout this manuscript, references were eliminated that would undermine the confidentiality of persons referred to.

The lives of people in farmworker households revolve around the nuances of the agricultural cycles of particular crops. This lifestyle requires, at the very least, a basic understanding of the biology of crops, road and weather conditions, geography, the intricacies of the agricultural labor hierarchy, and effective social networks. The first section elaborates on the lives of migrating farmworkers temporarily residing in Northern California.

Living and Working in Northern California: The Art Ochoa Migrant Center

Residents of the Art Ochoa Migrant Housing Center live in Gilroy, CA and work in Central Coast agriculture that includes the areas of Alameda, Contra Costa, Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz counties (State of California, 1994). Most of the farmworkers living at Art Ochoa worked in the Salinas Valley, known for its lettuce production.

Gilroy is located at the southern portion of the San Francisco Bay Area in Santa Clara County. Historically, this geographic area has been known for its rich fertile soil and as the garlic capital of the world. In the spring and summer, the climate is hot and dry; fall and winter bring cool and clear weather. Within a short driving distance are the Monterey and Santa Cruz coastal communities that are famous for strawberry, lettuce, pumpkin, squash, and other crops that thrive in this cloudy, windy, damp, and cooler climate. Farmworkers at Art Ochoa usually work in both of these distinct climate zones during peak season from summer through late fall.

This agricultural region is now on the outskirts of the rapidly growing and expanding Silicon Valley. Agricultural land is increasingly being converted into housing, shopping, or office buildings, so the Art Ochoa housing complex is almost hidden by the highways. Within its immediate vicinity, Art Ochoa is located next to a few privately owned labor camps that house single migrant male workers. Across the street from all these residences is a waste treatment plant. Surrounding Art Ochoa are agricultural fields, railroad tracks, and Highway 101. Within a mile there is a Wall Mart and a Kaiser Permanente primary health care medical clinic, and within two miles there is a relatively new conglomeration of more than 100 factory outlet stores. This urban growth presents

challenges for migrant farmworkers since affordable temporary housing is becoming increasingly scarce. The 96 families who live at Art Ochoa Migrant Housing Center are fortunate since it is one of the few modern and safe facilities available to migrant households in the area. Other farmworker households who migrate to this region for agricultural employment live in motels, cars, trailers, or in old, dilapidated housing structures.

Art Ochoa is open from mid-May through October. Farmworkers interviewed point out that it should be open longer since the agricultural season does not end until late November. The 96 units at the Art Ochoa Migrant Housing Center are designed for families, and most units have two bedrooms, a living room, and a kitchen with a refrigerator, air conditioner, stove, and oven. Rent is subsidized and is based on reported monthly income, and most heads of household reported paying between $200 and $250 for rent. This rent is well below market value since Santa Clara County is one of the most expensive rental and real estate markets in the United States. It is important to note that residents who live at Art Ochoa must prove that their family is a migrant household, and preference seems to be given to two-parent households.

Art Ochoa has a community room for meetings, laundry facilities, two public phones, a manager's office and residence, and a small primary health clinic open once a week. Each household unit has a parking space, the entire complex is fenced in, and pets are not allowed. Each unit has a small front yard with grass that some residents have converted to grow flowers, vegetables, and herbs. Overall, this publicly subsidized complex is well maintained, and individual households keep their units clean. Periodic inspections discover maintenance needs and encourage residents to look after their units.

Water, gas, plumbing, and electricity are reliable. Most households have local telephone service, and a few pay for cable television. Families interviewed appeared to have an adequate supply of food, bed linens, clothes, cleaning supplies, and cosmetics.

Of the 31 households who qualified and participated in the research study, most maintained a homebase residence in Yuma, Arizona. Others had a residence in the California towns of El Centro, Holtville, and Mecca in Imperial and Riverside Counties. Migrating farmworkers interviewed in this study maintained close contact with their homebase residence since they were responsible for rent or mortgage, utilities, and other bills. Most families found a relative or a renter to live in their home while they were migrating north. Some families even traveled once or twice a month to their homebase to make sure everything was in order. Therefore, they were occupied with the worries of maintaining two residences simultaneously. Most of the households interviewed at Art Ochoa migrated between the Gilroy area, Huron, and their homebase residence in the desert. As a matter of comparison, some migrating households in other "streams" migrate to multiple locations more frequently to find agricultural employment.

Given the isolation of Art Ochoa, households interviewed had to have access to at least one car. Toyota pickups as well as mid-size 1990s models of Hondas, Toyotas, Fords, and Chevys were popular. As a male farmworker pointed out, a well maintained automobile represents their livelihood. Farmworkers living temporarily at Art Ochoa still have a substantial commute because their employment may take them to Hollister, Salinas, Monterey, and Half Moon Bay, which can be up to two and a half hours away. Driving in the foggy coastal areas, where small two-lane roads are characteristic, is a known daily hazard. Farmworkers live with the fear of car accidents and a few

farmworkers interviewed experienced serious injuries from past car accidents that occurred while traveling for work. With the exception of elementary school buses, there is no public transportation that serves farmworkers in this area. Despite the presence of at least 100 stores a short distance away by car, no local grocery store within walking distance serves this temporary farmworker community. The lack of public transportation and other basic services within walking distance is problematic, especially for those who remain behind at Art Ochoa during the day– they are completely isolated. In addition, the public phones for Art Ochoa residents are also used by the men who live next-door, resulting in long waits to use them.

Residents at Art Ochoa communicate with their neighbors and most know each other by their first names. Neighbors share phone lines and exchange advice and rely on each other for everyday emergencies of rides and babysitting. A few women in the complex sell Mary Kay, Avon, and Amway products. Other women send their children door to door to sell homemade items such as cooked corn, tamales, and Mexican desserts, while others earn extra income by cutting hair. Still others sell floral arrangements and items for baptism, birthdays, and other occasions. There is a pattern to their routines while living temporarily in Gilroy– people wake up early, often before dawn, and are in bed usually before 9:30. Almost everyone speaks Spanish, and children are usually bi-lingual and at times translate for the adults.

Many women at Art Ochoa maintain two jobs: one at home and the other in the fields. It was always difficult to find a time when women could participate in an interview since they never seemed to have any time. When they were not in the fields they were cooking, watching children, shopping, cleaning, selling, attending a social

event, or helping someone else do their chores. Men on occasion return from the fields later than women since they may work double shifts. When men were in the complex, they could often be seen outside fixing the car, tending the garden, or talking with other men. Young boys could be seen running around the complex playing soccer or football or riding bikes. Girls ride their bikes, but they often play inside. Adolescents living at the camp were usually not seen "hanging out" since loitering was not permitted. Many, in fact, work in the nearby stores if they have transportation. Men and teenagers usually go outside the complex to socialize.

Art Ochoa residents were accustomed to having outside visitors from a variety of organizations. In addition to Rota-Care staff, civic organizations brought food and clothes while social workers and public health nurses interacted with residents who were their clients. Researchers, students, and reporters occasionally interviewed farmworkers. A variety of people from various service organizations still manage to interact with Art Ochoa residents regardless of their isolation and the fact that this camp is somewhat hard to locate.

By and large the Art Ochoa was peaceful and well maintained. The police occasionally patrolled the area, but their attention was usually directed to the men living in the adjacent camps. Residents of Art Ochoa agreed to follow the regulations specified in their rental agreement and disorderly conduct was unusual. There was petty theft and minor vandalism but these incidents were not common. Nevertheless, residents have a few significant concerns. The air often smells bad due to nearby agriculture and the waste treatment plant. Moreover, the area is not well lit at night and there are few services available within walking distance.

Health Care Services at Art Ochoa

Rota-Care volunteers staffed the on-site medical clinic weekly in order to provide basic check-ups and referrals free of charge for both children and adults. Since there was no on-site lab or no pharmacy and the clinic were sometimes staffed with non-physicians, clinic staff was limited to providing very basic primary health care and referrals. Farmworkers residing at Art Ochoa expressed gratitude over the availability of this free service. But the need and demands for services warrants consideration for expansion of primary health care services at this site. More specifically, one female farmworker commented that many farmworkers arrive home between 9:00 to 10:00 in the evening. She suggested that the Rota-care clinic remain open until late in the evening at least once a month to accommodate these farmworkers.

All of the households that I interviewed reported knowledge of the Rota-Care free clinic and more than 90 percent of the head of households reported that they knew where to buy medicine, where the nearest emergency room is, and where the nearest subsidized full service primary health care clinic is located in San Martin, CA. This knowledge is based on previous attempts by family and neighbors who sought health care at these facilities.

The Decision to Migrate

The decision to migrate for agricultural employment in a given agricultural season is based on several factors primarily on whether or not migration will be a profitable. Migration is either a planned, annual event or a sudden decision made when work is scarce in the homebase area. Most farmworkers interviewed had experience migrating even if they were designated as a non-migrating household on the basis of their most

recent work experience. It is important to point out that the analytical distinction between migrating and non-migrating farmworkers has its roots in federal programs that allocate funds for migrant health, migrant education, and migrant day care. In fact, when reading about the programs for farmworker families, many of which started in the early 1960s, one could easily get the impression that engaging in agricultural work is synonymous with migration since several programs are designed for migrating farmworkers and their dependents.

The availability of a unit at this housing complex allows families to migrate together and stay together and is a major factor that influences a decision to migrate to the Bay Area. If a family is not guaranteed a space at Art Ochoa, the adult male in the family unit may be the only person to migrate. The rest of his family would probably remain behind in their residence in the desert.

Previous migrating experiences influence the decision to migrate for agricultural work. For example, many farmworkers in this study reported that the working and living conditions in Huron, CA were very bad. Due to Huron's reputation, farmworkers interviewed reported that the male farmworkers would migrate to Huron alone after the work had ended in Gilroy while the rest of the family would return to their desert homebase. Most farmworkers interviewed in Gilroy reported an overall positive migrating experience while living at the Art Ochoa Migrant Housing Center. First time residents at Art Ochoa, however, report a more difficult migrating experience since they have to learn where everything was located, adapt to the climatic changes, and develop effective social networks.

As the business of agriculture has evolved due to technology and improved irrigation, work is becoming more available year round in some communities in rural California. One of the distinct contributions of this study lies not only in the depiction of the life, work, and health of migrating households, but also in the lifestyle in the homebase farmworker community of Mecca, California.

Living and Working in Mecca, CA

Mecca is located at the southern tip of the Coachella Valley, bordering the Imperial Valley. Desert agriculture begins in Southeastern California and extends into Western Arizona. In California, the Imperial and Coachella Valleys produce much of California's winter vegetables. Highways 8, 86, and 10 provide access into these areas. Agricultural crops grow in this desert climate when irrigated by the Colorado River. The main crops include dates, grapes, and citrus fruit. Farmworkers homebased in Mecca work primarily in the Coachella Valley. Families who migrate during the summer from Mecca often travel north to Gilroy, Huron, Fresno, or Bakersfield. This section describes the evolution of Mecca as a farmworker community.

Mecca in Historical Perspective

Mecca remains a small town located in an unincorporated rural area by the Salton Sea. Mecca has an advisory community council appointed by the county supervisor, and Mecca residents are under the jurisdiction of the regulations of Riverside County. However, it is important to point out that Mecca borders Imperial County and politically and geographically it is isolated from the wealth of Riverside County that includes the resort cities of Palm Springs, Palm Desert, Indian Wells, and Bermuda Dunes.

The geographic area that now encompasses the small desert town of Mecca, CA has its roots in a history that is more than a century old. At first glance, this area, characterized by its harsh arid climate that can reach 120 degrees Fahrenheit during the summer, seems an unlikely place for one of California's most productive agricultural regions. Mecca is located in the Colorado Desert nestled between the San Jacinto and San Bernardino mountain ranges and is approximately seven miles from the San Andreas earthquake fault (Foulkes 1985). The purple mountains and the amber sunset characteristic of the area mark the beginning of what is commonly referred to as the Southwest. The mountains that encompass Joshua Tree National Park stretch into the Mecca Hills on the outskirts of town.

Mecca began as a railroad settlement known as Walters more than hundred years ago. Several artesian wells, built there by the Southern Pacific Railroad, served trains traveling from Yuma, Arizona (Foulkes 1985). The mines and the railroad attracted people to this region in the early 1900s. In 1904, the area became known as Mecca, but this land has historically been home to the Chemehuevis and Cahuilla peoples for more than a thousand years (Laflin 1998). Currently, interspersed throughout the Mecca area are several parcels of Native American land belonging to the Cabazon and Torres-Martinez peoples.

In the first years of Mecca's history, agricultural production was not as prominent as it is today. Nevertheless, in recent years, vast parcels of previously arid land have been converted into large tracts of single crops irrigated by canals flowing from the Colorado River. Currently, Mecca is completely surrounded by grapes, dates, tomatoes, melons, and citrus fields. With increased agricultural production came migration of workers,

largely from the Mexican states bordering the United States. Eventually, Mecca evolved into a town where more than 90 percent of its residents speak Spanish as a first language and where the majority of its residents are involved in some aspect of agriculture production. Besides Spanish, other residents of Mecca speak English, Purépecha, and Tagalo. Farm labor is an integral part of Mecca's more recent history.

Farm Labor in the Coachella Valley

The interview passages below are from a bi-lingual former farmworker who explains what it was like to work in Mecca as agriculture was beginning to develop on a large scale. Conveniently, this passage also describes the United Farmworkers Union's role in local agriculture.

> *Former Farmworker*: I've been around farmers all my life. I was born and raised in Oasis area. I used to go up north. So I know what went on then and what is going on now!
>
> *Interviewer:* In the past, what were some of the most important problems or injustices faced by farm workers in the Mecca area?
>
> *Former Farmworker*: Even before Cesar Chavez. Cesar Chavez nationally did a lot. A lot of things started happening. Became unionized, sometimes I don't think it was the greatest thing, but then it was just the way it [the union] was run. They improved a lot, facilities and treatment of some of the laborers, the migrant farm workers. I remember all the way to the Braceros. That started improving a lot there, but not as much as when they started talking about unionizing. It was tough.

Interviewer: Why did they want to unionize? What were some of the injustices that they faced?

Former Farmworker: Because everyone else was unionized, they said why not us? We can form a union and get paid decent wages. We can demand this, demand that, just like the other unions. Things started happening ... Hey we need some water here– we need some bathrooms! What is going on? Things like that I was glad to see come into the picture because it was terrible the way things were. You had to carry your own water or you would die of thirst. Things like that! At least it is there in case things start getting bad, I assume.

Interviewer: Were there any particular problems that farmers faced in the Mecca area that were unique?

Former Farmworker: Like I say those things started happening. Some of the farmers started realizing they had a right here. They are in the right track; we have to do something. Because like in many other things: if you don't pursue them– if you don't push them, nothing ever gets done. You have to have something behind it and this is what Chavez was trying to do. A lot of good came out of it. Things were really bad at one time when I used to work in the fields.

Interviewer: What do you think are some of the greatest accomplishments that perhaps Cesar Chavez contributed to in solving these problems?

Former Farmworker: Well, he solved a lot of the problems actually, but it is too bad he didn't live any longer because I think it could have been a really strong union as far as insurance and retirement funds, wages, organized type farm laborer union. It could have been a lot better than what it is– I am sure. It started

out right at the beginning, but then it started leveling off– realizing what went wrong and how they should have handled it.

Interviewer: Today, what do you think are the most important problems or injustices faced by farm workers in Mecca?

Former Farmworker: Speaking about the past, the farmers were trying to do some good things actually. Having camps in their farms. It is not that they were not trying to help them out. They were. It made it good for them because they had people there whenever they wanted. I used to go over and eat with them many times because they would invite me over. I could see that they weren't just living underneath a tree. They had bunkhouses with a kitchen. Then we got the health department to put on a squeeze and the guy says hey we don't have to do this if we don't want to. We are doing it just to benefit some of our employees. But they didn't want to have some sort of a Hilton or something.

July 31, 1998

This informative passage illustrates that, despite the current problem of a shortage of housing for farmworkers, these workers faced even more obstacles in the past. This former farmworker alludes to the United Farmworkers Union's weak local popularity and attributes it not to ideological opposition, but to poor management. Newer inequalities, however, can be traced to how labor is currently managed. Independent contractors or "contractistas" usually hire and manage farmworkers directly for the growers. In this way the farm laborer works for the contractor and not the employer. When this happens, the worker does not customarily receive the benefits that one would if working directly for the company. Independent contractors are useful for the grower especially when they

only want to hire laborers for short periods of time. From observation in Mecca, I came to realize that independent contractors sometimes employ workers without legal documentation and often knock on apartment and trailers doors at night looking for those who want to work the next day. But there are other insecurities inherent in agricultural labor in the 1990s revealed the following passages from a husband and wife farmworker couple.

Interviewer: Isn't there a danger that the company, suddenly and without previous notice, says we are no longer a company and they quit the insurance?

Male Farmworker: Yes.

Female Farmworker: It's better that they don't, but they do. And they know that the majority of people don't know the laws, how things should be. Many times you don't know the law, we know what they say to us, or what they want us to know, no more, not exactly. If you begin to investigate well and all, perhaps you can defend yourself, but listen to me; we are 50 workers and no more than you talk...

Interviewer: They say goodbye to you?

Male Farmworker: They say goodbye to you and that is it.

September 16, 1996 Spanish version in Appendix 2

Job insecurity pushes many farmworkers to change jobs frequently. In fact, some farmworkers could not even remember the name of the company that they worked for and many had to look at their pay stubs before they were able to state which company employed them. Agricultural employment in California operates in a competitive, time sensitive, market-specific, and weather-dependent environment. Massive agricultural

conglomerates increasingly have replaced small family farms. It is in this environment that farmworkers and their families work for a living.

Mecca in the 1990s

Despite the insecurities inherent in this business, Mecca in the 1990s continues to grow, in large part due to the booming agricultural industry. Currently, Mecca is quickly changing into a major farmworker community. Even though the 1990 census reports that close to 2000 people reside in Mecca, the actual figure is closer to 5000-6000 people, according to a variety of local agencies which estimate the population on data from utility companies. Mecca, however, is still a small town where most people know each other. There are three small family-run grocery stores, a post office, a small library, two elementary schools, at least five formal day care programs located in three buildings, at least four churches of different Christian denominations, one gift shop, one beauty salon, two restaurants, one laundry place, one video store, one long distance telephone center, one hardware store, one income tax service, and at least four money order services. Unofficially, there is a pizza delivery service run out of a home, along with other businesses that informally sell all sorts of household items.

Officially, the Mecca Health Clinic, located in the Nueva Vista apartment complex, provides licensed primary health care services from at least one physician, two nurse practioners, two nurses, and several medical assistants. A laboratory technician performs basic laboratory procedures for patients of the Mecca Clinic. More sophisticated tests are sent to a regional laboratory. A pharmacy, located in Indio, CA will deliver medicines ordered by Mecca physicians for clinic patients. However, Mecca residents will also obtain prescription medications that were originally purchased in Mexico.

Moreover, in 1998 a private physician board-certified in internal medicine, rented an office next to the hardware store. There are no formal dental clinics in Mecca, although there are a few unofficial dentists trained in Mexico offering services for low fees. Occasionally, volunteer dentists affiliated with Loma Linda perform free dental exams for school age children in Mecca. There are also alternative health care practitioners from Mexico with varying degrees of formal training, practicing in undisclosed locations in Mecca.

People residing in the Mecca area live in a variety of housing arrangements since there is still a shortage of dwelling units, especially during peak harvest season. I estimated that in 1999 there were at least 300 homes, 275 subsidized apartment and home rental units, at least 500 trailers, and approximately 100 mobile homes. During peak season in 1998 and 1999, from April through July, migrant farmworkers lived in approximately 200 cars parked in the parking lot of the grocery store. There were also cars with farmworkers living in them parked along isolated irrigation canals and on small ranches. Of those living in the cars, more than 90 percent were men with families in Mexico. Occasionally, there were a few young women. I participated in community outreach to the people living in the cars, and I came to realize that most were homebased in the northern states of Mexico, the majority from Baja California Norte. A few of the men were homebased in Arizona. All the men speak Spanish and many understand some English. A few were tri-lingual in Brazilian Portuguese, Spanish, and English. These migrant farmworker men lived out of their cars from May through July and usually stayed in Mecca Sunday through Thursday evening. On the weekends, they returned to their homebase residences in Mexico or Arizona. Facilitating this frequent travel were

border-crossing visas. Interspersed with the migrant men living out of their cars were a few local homeless people who lived under the palm trees. These homeless were usually bi-lingual since many were born in the United States. Occasionally these homeless men would compete with the migrant men for work in the fields. Many of these homeless men live with the challenge of mental illness and/or substance abuse and are sometimes mistaken for migrant farmworkers and profiled by the local and regional press in their annual stories on farmworkers.

There is also a significant presence of non-Spanish speaking non-migrating farmworkers living primarily in run down privately-owned rental units in Mecca. They are known as the Tarascan people from the state of Michoacán in Mexico. They speak a language referred to as "Purépecha" and most work in the citrus groves. These farmworkers are one of the most exploited groups living in Mecca and are much discriminated against. They live together and stay relatively hidden from public view. They rarely go out except to shop or watch an occasional planned sporting event similar to basketball. Many are unauthorized to work legally in this country and are systematically exploited by crew leaders. They earn on average one to two dollars per hour less than Spanish-speaking farmworkers for the same work. The local grocery store staff that cashes their checks daily observed this differential in pay.

On the outskirts of Mecca, there were at least 10 privately owned trailer parks. Many of these trailer housed families, but a few were tailored to single male occupants. Although there were some well-maintained trailers, others were dilapidated and posed safety hazards due to questionable electrical and propane connections.

Characteristic of Mecca is its continual growth. The struggle to adequately house

permanent and migrant farmworkers who travel to Mecca looking for work is on-going. Even though this research project effort designates Mecca as a homebase location, Mecca is also an area where people migrate to look for agricultural work. Housing is a pressing issue, given the presence of hundreds of men living out of their cars during peak season.

Permanent Mecca residents face the problem of creating adequate subsidized housing for farmworkers and other low-income residents. Furthermore, the attempts to build more subsidized housing have been linked to the building and financing of the Mecca Health Clinic. Financing a subsidized satellite clinic, like the Mecca Health Clinic, is in part based on population estimates of who might potentially seek the primary health care services offered by this clinic. These clinics, as well as other rural clinics serving farmworkers throughout California, are more likely to receive additional federal, state, and private foundation support if they can prove increasing levels of medical need. When people, most notably farmworkers, live unofficially in garages, sheds, and isolated trailer parks, they are not adequately counted in population estimates when grants are written. The following section traces the efforts to establish subsidized housing units and a primary health care clinic in Mecca.

Building Subsidized Housing and a Medical Clinic in Mecca

Attempts to build subsidized housing were not easy and required the ingenuity of many dedicated people both inside and outside of the Mecca area. The construction of the subsidized units for low-income residents in Mecca, as well as the building of the Mecca Health Clinic, was accomplished by the very public and award-winning efforts of the *Coachella Valley Housing Coalition*. Their efforts, although not without conflict, were buoyed by a broad-based coalition of community support. The following interview

passages reveal the complexity of this process. It is important to note that all references to individual names have been removed.

Farmworker Advocate: The housing here was developed with tax credit financing, which is a method used for affordable housing whereby larger consortiums [groups of investors] pool their money and purchase tax credits. And the amount of money they purchase it for usually, they get a dollar's worth of tax credit for something like 60 cents on the dollar. We use that money as part of the financing for the apartment complex. We had additional financing from the State Department of Housing and Development– Family Housing Demonstration Program. That was a competitive process where we competed with other organizations, and the family housing demonstration program has a child-care requirement, a job-training requirement.

Interviewer: We do have the Employment Development Department coming out to these apartment complexes almost every month.

Farmworker Advocate: Yeah they do. And that was their level of commitment. We still have to get that up and running a little bit. It is new and we are also very unique in that we chose to add a medical clinic.

Interviewer: Elaborate on this because this is one of the most important reasons why I came to Mecca.

Farmworker Advocate: We did the medical clinic because at the time there was a need for a medical clinic down here. At the time that we wrote the grant, El Progresso was still in business. They were located in Coachella. They were not here in Mecca, so people in Mecca would have to go to Coachella for services.

This often was difficult for people. Some of them did not have cars. Some had transportation that was not reliable. In the initial grant we planned that with El Progresso and the thought was that they would operate it. They helped us on the grant. They helped us design the medical facility. I think for a housing developer, they are going to have to work with someone that will tell them how to do that.

Interviewer: Because this is a primary care clinic and not a tertiary care unit?

Farmworker Advocate: I'm not sure what all that is, but that is why we needed to rely on someone who knew the rest. As it turned out even before we started building, El Progresso folded and there we were with a medical clinic being investigated. We heard very good things about the current provider– Clinicas in Brawley. Went down to visit, went on a tour of all their various health clinics and then arranged an agreement with them where they would lease this medical clinic. I think it has been two and a half years. It has been a great contribution.

Interviewer: Did you have to deal with any difficulties on the politics for establishing several low-income housing units?

Farmworker Advocate: Yes. We had huge difficulties. We called our effort the Mecca Revolutionary Army!

Interviewer: How did you overcome this opposition so that you could put these housing units here?

Farmworker Advocate: People who worked with various supporters and us met with self-help homeowners. We built 66 self-help homes in Mecca. These are all subsidized with US Department of Agriculture funds.

Interviewer: They are rural funds?

Farmworker Advocate: Yeah. So we gathered and met with our natural supporters. We did a lot of community outreach. We went door to door and got a petition. This is something I am not going to remember the numbers on– the petition– but it seems to me it was over 900 maybe 1000. When we didn't do that, we hung out near the post office. There was a meeting with the Mecca council. I think perhaps there were 200 people there that were....

Interviewer: That is huge for the Mecca community!

Farmworker Advocate: We got out the vote. The city council I think was negative about it. I think also that it was coming to a vote without us being aware of it, so we had to be rather vigilant. The [county] supervisors, I remember, did come to the meeting. They would accept the vote of the Mecca council. They are not really legal. They don't have strict jurisdiction, they are advisory because the area is really run by the county. They held it over to this other meeting and this meeting was where they just would vote. I think it was that meeting where we brought the postcards. After doing all the petitions, we went back and got postcards done.

Interviewer: That was smart. How did they do it, did they have to mail them in?

Farmworker Advocate: I believe we mailed them in. I think. At this second meeting where they held it over, as I recall, I am not the one with all the details. Again we had to be vigilant. I don't remember. There was a second meeting and people were encouraged to go. There weren't 200 people, but there was a significant number. By the way, in the first meeting there was a great deal of

comment from residents in Mecca supporting the project. And sometimes it got really heated because they supported it really strongly!

Interviewer: Essentially, if I understand correctly, you went door to door and you got people to make their presence felt at the community council? Basically the community council supported it at the end. You were able to build it?

Farmworker Advocate: I think that is about it as far as what I can say. Oh, I want to back up a bit to the Mecca Revolutionary Army because, jokingly, all the people who came down here are Hispanic. Our office staff has certainly strong ties with the community and comes from a farmworker background, and especially the office staff that is working with self-help housing, the loan packages, and the intake people.

Interviewer: You make a little money to maintain and pay salaries and still you are able to keep relatively low rent? How is it that you manage that?

Farmworker Advocate: We scramble.

Interviewer: Do you get grants?

Farmworker Advocate: For some programs like the rural housing we rely on the Department of Agriculture. For our tax credit project that has gotten more competitive, various people both profit and for non-profit. We are non-profit. Some of the for profit people, they want to get in and out. They want to build it, get profit and get out. So we stick with it and make the community services as much as we can do with various funding sources. We are just look for funding. We are vigilant and we move with funding and with the programs that are available. The family housing demonstration program may not have any more

funds available. I don't know if that is up for re-funding or not. It might be a program that may go away. Some of the programs that provide subsidies for some of the apartments have gone away. As far as paying salary, we don't make a profit. As far as paying salary is concerned, it is part of our developer fee. Part of the cost of making business. We don't always recruit either.

Interviewer: I know the clinic is operating at a deficit. They always do but they have grants to replenish it. But they are going to face– Medi-Cal will no longer be granted to new immigrants even if they are here legally. Three or four years down the line they are going to have tightening of the belt. So I am wondering if some of these programs are doing the same thing?

Farmworker Advocate: Yes, they are.

Interviewer: August 22, 1996. You have to be there before then to get federal subsidies. I know the clinics will be, I just don't know if you will be affected. Under which program that will be under.

Farmworker Advocate: It is under all of them. It is just a question of declaring housing of public benefit. So there is a cost of building a complex and there is a mortgage that needs to be paid. A gap that you need to pay for the rent and what is affordable is how we use subsidies. If that subsidy is declared a public benefit, then we get into the immigrant clause going back to August of 96.

May 4, 1998

The passages above reveal the complexity of trying to provide subsidized housing for farmworkers and other low-income recent immigrants and the uncertainty revolving around the immigrant legislation that passed in Congress in 1996. Since then, parts of the

federal legislation have been slowly circumvented by a variety of bills passed in 1998 and 1999 by California legislators. This effort also led to the building of a primary health care clinic in Mecca. However, attempts to address the housing needs for migrant workers in Mecca have been more complex. The following section explores this issue in greater depth.

Housing Struggles for Migrant Households in Mecca

Despite the remarkable progress made in the construction of dwelling units for farmworker households living in Mecca, there continues to be a phenomenal need for housing for migrant farmworkers. The following interview passages with a local grocery store owner, who used to work in the fields as a child and young adult, reveal the history behind this current problem.

> *Former Farmworker*: These people just come to work. We can't do without them. People out there don't realize that we can't do without these people. Who is going to pick all the grapes, watermelons, cantaloupe, and the tomatoes, corn? Who is going to do it? We can't do without them. If they are going to put food on our table, it is not right to have people living out there like a bunch of animals. I do the best I can [He provides a safe lighted parking area for migrant farmworkers}. Then there is opposition because it doesn't look very good. Well, I know that, but we can handle it for a couple of months. It is no big deal. I clean everything out like nothing happened. At least they got bathrooms. People don't realize that if work is there, people are not going nowhere! They are going to stay where the work is even if they have to go do potty by the sticks or wherever! At least this way they have bathrooms and they are underneath a lighted area. They

don't have to go across the railroad track or behind the church and get run over by a car and get mugged for one thing. Payday– if they sleep out there by the bushes, people are going to rob them. They get paid, get a little tipsy and this is what happens. They [the migrant farmworkers] appreciate it because they tell me.

Interviewer: You are talking about the parking lots that you provide?

Former Farmworker: Yeah. XXX understands. Thank goodness. But the sheriffs, or whoever is putting the pressure on, it is making it seem like, hey, why should we let these people come in here. It is just Mecca. They could be anywhere else in Oasis, and nobody bothers anybody. They are there underneath the lemon groves and there is no problem. When it comes to Mecca, some people over there are putting pressure. The people, they don't bother anyone. They just don't like the scene, but it is all over. When I used to follow the crops, it was everywhere. I remember when my dad used to put up a tent. Just keep moving.

July 31, 1998

The above passages illustrate, from the perspective of this seasoned farmworker and current grocery store owner, the current housing situation for largely single migrant males seeking agricultural employment in Mecca. The storeowner is facing political pressure from a variety of sources because he provides lighted parking lot spaces for these men near his store that is located at the entrance of the town. There was a time, however, when farmers provided their workers with free or low cost housing. But many of these housing facilities were in poor condition and on January 14, 1983, the Migrant and Seasonal Agricultural Worker Protection Act signed into law stated that these housing facilities had to meet specific federal and state safety and health codes (Johnson

1985). The following passages, from the same storeowner, reflect the unintended consequences of these laws for migrant farmworkers seeking work in the Coachella Valley.

> *Interviewer:* So, you are saying that in the past, the growers provided housing and today they don't provide housing, so in some way it has deteriorated?
>
> *Former Farmworker*: They are destroying and getting rid of all the camps. Because– just about every big farm had its own camp. They had a cook and they had the people staying right there. They weren't charging them anything. I thought it was a good idea because I used to supply a lot of them with groceries and they always paid and made good food. But like I say, that is exactly what happened. You got to have a door that shuts automatically, fans. These are the types of facilities you need if you want to run a kitchen. Well, we are talking about a lot of money. What they really wanted was a real modern type kitchen, industrial kind.
>
> *Interviewer:* They couldn't do that?
>
> *Former Farmworker*: No, it would have cost a lot of money to go through all that. What did they want, fans on the doors and wow none of this had to do with the health department. I know because I have a mini-market, I know what they meant for us to do. Different kinds of floors, vents, and fans– it was just too much. They would have to have fire insurance and all that. They didn't have to do that. They [various government officials] said well, you either do that, or knock them down. So that is what they [the growers] did.

Interviewer: Right now you say the most important problem is lack of housing?

Former Farmworker: I would think so. There are a lot of locals that bought their own home. But there are a lot of them that don't because they are not here that long. They are here during the harvest. There is nothing out there to help these guys, and yet we can't do without them. I always feel sorry for them, and I have been backing them up now for 20 years and I haven't accomplished a darn thing.

Interviewer: What do you think should be done about it? I know you have answered this question many times, but I want to hear it. What should be done about housing for the migrants?

Former Farmworker: They didn't want anything serious. They wanted a place to park the car, make some barbecue meat, and take a shower. They had the place and we worked on it for all the times XXX was in office and we could never accomplish it because we had other organizations that would say, "Well you are not building anything for these people! The cows in San Joaquin Valley live under air-conditioning; you are trying to put these people up in the middle of nowhere!' I don't have anything against housing if you can get the money, but these people were suffering, and they are still suffering because there are these guys that live in air-conditioned houses and couldn't care. If they care-- they didn't show it to me because if they had let that happen, it would have been better than nothing. I could never say that, because that was a bad word. ...

These people (migrant farmworkers living in cars) don't want to come and pay and spend a lot of money on rent. They will sleep in the car; they will sleep somewhere. To them it is nothing to sleep out in the open as long as they can

have a place where they can go eat the next day. I am sure they don't want to spend a lot of money. If that is the best they can do well give it a try. I am sure there will be some people that might want to rent. They are going to bring their wives over and we got family involvement here. Is that what they want, we got houses as far as that goes. If they want to rent, there they are. We have a lot of homes in Mecca. But there is nothing to help the sole worker. This would have been great.

Interviewer: You are talking about a campground?

Former Farmworker: That is all they want really. Nights are cool, and then they can take a shower. These guys can't take showers. A place where they can wash their clothes– great! They are all piled up in a couple of my lots. People say here comes problems, these people are going to get drunk here, and they are going to raise hell. Well, it doesn't happen.

July 31, 1998

One of the most revealing aspects of this interview is the differing idea on what should be done for the temporary migrant males living in the parking lots. In the past, most growers in the Coachella Valley provided housing for their workers. However, with the advent of the new health and safety codes designed to protect farmworkers from abuses, most growers unexpectedly decided that it was no longer profitable to continue to operate living and cooking facilities for farmworkers. Thus, instead of making improvements, they closed the housing facilities. Growers, some lawyers, and even a few farmworker advocates, whom I interviewed emphatically argue, that the various federal, state, as well as county regulations that arose from the original federal legislation made it

very difficult, if not impossible, to provide decent and affordable housing structures for farmworkers. Since growers in this region no longer provide housing for farmworkers, there is a critical shortage of housing, especially during peak season when the town's population doubles. As mentioned in the interview passage, the men live in the parking lots of local grocery stores. Other men live in remote trailer parks. No matter where the men sleep at night, hundreds of men congregate around the town center during peak season. Overall, the men are usually respectful of others. However, at times, there are problems with public drunkenness and littering. The perception of many permanent Mecca residents, many of whom began their working careers as migrant farmworkers, is that the presence of these workers in the town center may put unescorted women at risk.

The local grocery store owner suggested installing showers and bathrooms near the parking lot. This less expensive idea would allow the men to continue to live a rent-free existence in the parking lots, and would improve the sanitation of the people living in the parking lot. Opponents of this idea argue that it is not enough. Other opponents want to get the men to leave this site and go to place that is less visible.

In November 1999, a housing structure for migrant farmworkers that can accommodate 88 people was completed on the outskirts of Mecca. Despite some initial problems in its construction, it is now ready to rent out rooms to single migrant males for 25 dollars a week. At this point the new housing facility is a bit isolated and there is no public transportation directly serving this living residence. However, the building of this structure represents a significant attempt to address this important issue. It remains to be seen whether or not there will be fewer cars parked in the parking lots in the future.

Once one travels beyond main-street, with its stores and the men living out of their cars, life in the houses, trailers, and apartments within the town's limits resembles the lives of other working families living in rural America. The following section examines the lifestyle of migrating and non-migrating farmworkers homebased in Mecca, CA.

Farmworkers Homebased in Mecca, California

The people living in 99 farmworker households interviewed for this study have lives filled with competing and demanding work, school, sports, religion, and family responsibilities. Even though farmworkers are engaged in an occupation that is as old as humankind, their children experience modern pressures. Despite their rural existence, these children are well aware of the world outside their lives: images received through school, the Internet, video games, and television programs promote the lifestyle of an urban existence.

So what contributes to Mecca's continual growth? What are the benefits to this type of life? One woman stated emphatically that Mecca provides a "family oriented lifestyle." Farmworkers with children in Mecca often follow this routine: At 5:30 in the morning they drop off their children at day care. (The day care staff takes some of the older children to school at around 8:00 am.) Parents are in the fields by 6:00 am and work until 2:00-3:00 in the afternoon. From work, most farmworkers go directly to school or to day care and pick up their children. In fact, in Mecca, the only predictable traffic jam occurs every weekday from 2:30-3:30 in the afternoon as the school day comes to a close. Most farmworkers are at home by 4:00 with their kids. They shower and change clothes. Women usually begin to prepare dinner, kids play and do their homework, and either run

errands or relax. After dinner, people rest and watch television, or some take a walk outside and casually meet with their neighbors. On Saturdays, most farmworkers work from 6:00 a.m. to the early afternoon. The weekend begins on Saturday afternoon and this is usually characterized by housecleaning, laundry, short trips to Mexicali or Los Angeles, visits with nearby relatives, parties, church services, shopping at neighbors' garage sales, and out-of-town shopping. This routine in Mecca starts in September and goes through early June. In the summer, those who migrate to Northern California leave as soon as their kids finish school. In some households, the car or van is packed and families may take off the day school is out and migrate north for agricultural employment. The process is not random. Most of these families know at least where their first job is and where they will be staying. Those who do not migrate remain in the blistering heat of Mecca. Some farmworkers will get unemployment during this time and take a vacation. Other farmworkers will work unofficially in another occupation while receiving unemployment. Still others work year round in agriculture.

Mecca, however, is not without its problems. The following passages, from an interview with a former community health worker and current farmworker in Mecca, elaborate on various aspects of life in Mecca in the 1990s and address many public health concerns.

> *Farmworker:* In the past, the former clinic contacted farmworkers for community service. The job consisted of investigating the major problems of the community. For example, here in the community, we have people who now live in parking lots, living in the fields. We had to see where other needs were– school needs, domestic violence, and health problems– all the problems of the community. And

what we were doing was on the part of the clinic– to see where we could help. We would examine a case. We would give information, where one could obtain assistance. We tried to get people and the community to progress. It was our job to know all the public and private services were people could go to resolve these problems.

Interviewer: Do you know about the Mecca clinic?

Farmworker: Yes.

Interviewer: How can we improve the clinic?

Farmworker: Well, here in this community of Mecca, we have many huge needs. First, we have the problem of emergency care– we have none! Here in this town we do not have paramedic services. If we have an emergency, the ambulance arrives in twenty minutes or even in a half an hour. Twenty minutes is valuable time for a person in an emergency. We have problems with women in labor. In my case, when my wife was about to give birth to our child, no one would give her a ride to the hospital. My wife had to go by bus. Once arriving in Indio, she had to transfer to another bus to the hospital. On her way from Mecca to Indio she was sick and in labor. Once she arrived to the doctor, they sent her to another hospital clinic because there were no emergency services.

Interviewer: What other needs to you see?

Farmworker: Well, the needs are basic needs. For example, medical attention for children. Even though I see that we have a health clinic, there is so much demand and so few medical personnel to attend to the people. But I believe that our people believe that without health we cannot function as parents, as workers, our children

cannot function as students, and our wives cannot keep up with the house. Our children in Mecca have the same problems that we see in communities in Mexico. They have problems with intestinal parasites and lice on their heads. They also have problems with anemia. Therefore, here in parts of this country such as Palm Desert, where there is money, these problems do not exist. Here, our community is poor, the needs are basic, and there is no one who worries about us in our homes, and there is no effort to announce these problems since they are not acknowledged.

Interviewer: In the Mecca clinic, there is one doctor that speaks Spanish. Do you think we need more health professionals? What do the people think of the clinic?

Farmworker: The clinic is fine. They are trying to serve the community, but it is very limited. But realistically, the capacity is limited. In a normal day, the doctor cannot spend real time with the patient in order to provide a good service. Then what happens is that they just pass patients through without providing a good service. From my own experience, they don't have bad doctors. The doctor here is good. He is interested in you, and tries to give you the appropriate time to take care of your illness. But in the case where there is so much demand, we are many in need. We have more need in different area. In my personal opinion, I would like to see that the community receives basic services along with different medical specialists for this community and the surrounding communities. This is a very small clinic for our population, since it is so big.

Interviewer: Do you know how many people live here?

Farmworker: I don't know what to say, but Mecca in the last eight years until today has tripled it population.

Interviewer: They say that there are only 1800 persons, but I think there is a lot more.

Farmworker: The reality is that Mecca is a town that has many migrant workers passing through. But a good majority of these people have remained in Mecca because Mecca has seen double, no triple the number of housing units. But despite this, medical services don't exist– these services have not grown in Mecca.

Interviewer: I understand.

Farmworker: Only the population. However, the type of needs have not grown. Mecca continues to be a town with relatively simple medical problems that affect a lot of our population. These problems are relatively simple for government officials to solve if they knew of them. We could move forward.

October 26, 1997 Spanish version in Appendix 2

This interview passage is especially powerful in that this farmworker and former community health worker revealed many of the most salient issues affecting the health of farmworkers living in Mecca: transportation, emergency care, domestic violence, the need for a larger primary health clinic, poverty, and the conditions most common in children– anemia, intestinal parasites, and lice. When the tape recorder was turned off, he also elaborated on other significant problems facing Mecca residents. In the recent past, Mecca was a major transfer point for Mexican drug traffickers and according to locals, even made the cover of *Marijuana Times*. He added, "Sabes porque nosotros no podemos

salir adelante? Es por los narcos." Translated, "Do you know why we can't move forward? It is because of the narco trafficers." Related to this are the problems of alcohol and drug addiction. When he and his son were hired to pick up the garbage, they would see syringes lying on the ground. He later stated it was difficult to implement changes because that meant that people would need to become more conscientious of their own situation and make demands– like cleaning up the drug problem. This farmworker is an engineer by training and when he came to the United States he thought people would be freer. He pointed out, however, that powerful families dominate others in Mecca just as they do in Mexico. Nobody in the community council could clamp down on the drug situation because they were afraid of repercussion. Apparently there was a man who spoke up about the drug problems, and he was killed in the mountain behind Mecca. We also talked about the types of drugs sold- synthetic drugs, such as crack and crank, are the most common. Presently, he estimates that many small families are involved in the drug trade, selling small amounts. This is one way the "narcos" maintain their power and the people's silence– by getting several Mecca residents to sell small amounts so that everybody is involved. Therefore, due to the isolation of Mecca, its close proximity to Mexico, and the fact that only one police patrol car covers an area more than ninety miles, an underground network of drug trafficking continues. Drug busts occur annually, but the problem persists. In fact, one can easily observe drug transactions in the grape fields at night. This impacts farmworkers directly since they need to work in fields littered with syringes and broken glass from beer bottles. The problems related to substance abuse continue to be a public health threat to the children of migrating and non-migrating farmworkers, as well as other residents, homebased in Mecca, CA.

Substance abuse also contributes to the social problems of domestic violence, unplanned pregnancies, petty theft, and impaired driving.

In all fairness, however, most towns in the United States have to deal with the problems created by substance abuse. It must also be pointed out that among both men and women, smoking is rare. Moreover, alcohol use is low among women and substance abuse during pregnancy is uncommon. In crime statistics specific to the Mecca Township and its immediate vicinity area, for the years 1997 and 1998, the most common crimes were traffic violations and minor drug offenses (Unpublished data, County of Riverside 1998). Despite the perception by outsiders that Mecca as a crime-ridden town, in reality, violent felonies are low, and thus Mecca is a relatively safe place for farmworkers to live. Farmworkers homebased in Mecca, most of whom were born in Mexico, have an amazingly strong work ethic. Many report that their standard of living is higher residing in the United States than it would be in Mexico.

This segment has discussed the lifestyles of both groups of farmworkers and has also alluded to some of the public health concerns facing members of both migrating and non-migrating households. The need for medical services of both types of households should be put in the context of what medical services farmworkers seek. For that reason, the remaining sections of this chapter elaborate on the medical conditions reported by migrating and non-migrating farmworkers and their family members.

Medical Conditions Reported

Farmworkers are very eloquent in describing the health problems that they experience. The following interview passages illustrate some of the medical conditions that they associate with working in agriculture.

Interviewer: What are the health problems that farmworkers experience?

Female Farmworker: Well, because we are always in the rain, in the sun, in the water while working. We get colds and pains– chest problems, all types of illness; arthritis. Our hands hurt, our bones hurt. We have pains in our back, the waist, later our feet, hands and all our body hurts because we are working in the fields.

September 29, 1996 Spanish version in Appendix 2

When asked the same question, the following male farmworker replied,

Male Farmworker: For us, the most frequent problems are colds and flues due to the changes in temperature. And when one does this for many years in the same type of work, one begins to have problems with arthritis, rheumatoid problems. Problems with asthma also affect those who work in the fields. And regularly what I see at work among my co-workers is asthma, bronchitis.

September 20, 1996 Spanish version in Appendix 2

Another farmworkers stated,

Male Farmworker: They are strong, strong health problems. There is contamination of the blood that is cancerous– leukemia. This is one of the principal problems. The other is bronchitis and problems with our lungs– when we breathe. We also have problems with our hearing and sight. Sometimes people working in the fields feel dizzy because they have had too much sun. Then they take a salt pill to continue working and fighting this feeling off.

March 4, 1997 Spanish version in Appendix 2

Another farmworker added,

Female Farmworker: The health problems are here (pointing to his waist), pain in the waist and pain in the back. And when there is a lot of sun, sometimes one feels dizzy and you can get a headache from the sun and a burn on your face. There are also those people who are not accustomed to using bandanas like the majority of us do here. Sometimes, I can't breathe with the bandana because in the grapes you have to be completely covered otherwise you will suffer the combined effects of the hot sun and the sulfur that they put on the grapes. For this reason we are covered, and if you are not covered the sun will burn you. And there is another reason. If one gets near the ditches, sometimes you will slip and hurt your foot.

Interviewer: Do you have other health problems from working in the fields?

Female Farmworker: Sometimes there are irritations. For example, right now I am brushing the grape leaves, and since I don't have glasses and they don't give us glasses, my eyes suffer from the sulfur. Sometimes they can get so irritated that one cannot see. And when we brush the grape leaves, the sulfur dust gets in our eyes and you cannot see. This dust also hurts you throat and your nose. My nose is always irritated because of that sulfur dust.

March 11, 1997 Spanish version in Appendix 2

Illnesses reported among migrating and non-migrating farmworker households were similar. Farmworkers detail histories of muscle aches and strains, allergies, dehydration, arthritis, sunburn, respiratory problems, and fatigue. Farmworkers frequently stated that exposure to chemicals– fertilizers, pesticides, herbicides, anti-

fungals, etc.– often made them sick. Symptoms attributed to exposure to various chemicals include eye irritation, nausea, diarrhea, skin rashes, hives, and sores. Farmworkers in this study pointed out that they sometimes were asked to eat the grapes prior to picking them in order to see if they were ripe enough. When this happened, stomach complaints such as nausea and diarrhea were attributed to the yellow sulfur dust coating the skin of the grapes. Farmworkers attributed changes in temperature during the day– from the cool morning to the sweltering heat of mid-day– as a cause for illness. Farmworkers also reported work-related accidents such as from falling from trees, machine-related injuries, and automobile accidents. A few farmworkers expressed concern that their occupation put them at greater risk for cancer later on in life.

Women farmworkers reported more bladder infections than male farmworkers and that the dirty bathrooms increased their risk for infection. Women farmworkers also stated that they felt that chemicals used in agriculture caused miscarriages.

The most frequently reported concerns arise from exposure to pesticides in the work environment. Previous research documents acute clinical conditions attributed to pesticide exposure: systemic toxicity, dizziness, nausea, headache, and sudden death. Some of the long-term consequences also documented include Bell's palsy, Guillain-Barre Syndrome, Parkinson's disease, anemia, asthma, deafness, stillbirth, pancreatisis, and porphyria (Sakala 1987). The Environmental Protection Agency has, in fact, estimated that there are at least 300,000 farmworkers each year who experience acute pesticide injuries as a result a exposure (MESA 1995). The following excerpts from farmworkers sampled in this study illustrate pesticide concerns.

Interviewer: What health problems do you see among farmworkers?

Female Farmworker: Well, right now I see more problems related to insecticides, allergies.

Interviewer: Explain?

Female Farmworker: The problem with pesticides gives one headaches, stomachaches and allergies as a consequence. Allergies affect the body in the form of pimples, rashes. Sometimes one's vision becomes cloudy. This is what affects those who work in the fields the most.

Interviewer: And the children of farmworkers?

Female Farmworker: I have seen some. I have worked many years with agricultural companies- many children are born with birth defects.

Interviewer: How?

Female Farmworker: How? I don't know what they call it here, but we call it "tontitos." The problem is this, they are born with some type of mental problem, or some type of problem with vision, or their ears don't hear, or the [problem with] speech.

Interviewer: What do the people say?

Female Farmworker: Well, some say the fault is [pesticides], others say its other illnesses, and I don't know what to say. But I work in the fields and I have noticed that they apply insecticides and I am out there working in the field. Sometimes they apply the insecticides in fields close to where I am working. [The insecticides] cause headaches. Last year this happened to me and I became dizzy. And they keep spraying the field and we keep working close by, and later, later, I

have a reaction because I continued to work and suddenly I have a headache and a pain, and a foul odor in the nose.

Interviewer: What was the chemical called?

Female Farmworker: I don't know because the airplane was retreating and I don't know what they call it.

September 19, 1996 Spanish version in Appendix 2

The passage above illustrates what farmworkers perceive as the relationship between pesticide exposure and allergies, as well as the concern about the potential for birth defects. Huron, CA has been in the news over the past few years because of the harsh living conditions reported by farmworkers. Men in the sample for this study tend to migrate to Huron without their families in part due to the unhealthy environment and the perception that Huron is perceived as a dangerous and crime-ridden town. The following recalls a pesticide-related death.

Interviewer: What are the health problems among farmworkers?

Female Farmworker: I know, regularly I hear that they have problems with the fertilizers. I also had a friend who died. She worked a lot with fertilizers and they gave her a problem with her lung. She would cough and cough a lot. She spent a lot of time undergoing treatment, she left her work, and they sent her to Phoenix, they sent her to many places, they did many tests and things and nothing helped her. She used to work a lot in the grapes. And finally, this is what they told her, that the fertilizers affected her a lot. She could hardly breathe. It was like asthma. And then she was pregnant and gave birth. And now we all look at the child who is now five year old. And this child has the same cough that her mother had, she

coughs and coughs-- it is a very ugly cough.

Interviewer: Perhaps it was tuberculosis?

Female Farmworker: No they tested them both for that. It was no more than a lung problem from the chemical that they used. During this time she was especially affected because she was pregnant and her lungs were too congested.

Interviewer: What was the chemical called?

Female Farmworker: I don't know. This is because it was seven years ago and they keep replacing [changing] the chemicals that they put on [the crops]. But the chemical is like all the others, they keep replacing some with others, but all the time the [growers] will never stop using them. And this time when I go back [to Arizona], I am going to investigate what the chemical is called because this [incident] didn't happen in Arizona, there aren't any grapes in Arizona, but perhaps the mother [of the women who died] will know because her granddaughter lives with her.

September 19, 1996 Spanish version in Appendix 2

This case describes a situation in which a chronic lung problem contributes to the death of a female farmworker. As this farmworker recalled her friend's struggle with the illness, it became apparent that the exact cause of her death remained unclear. After eliminating other medical conditions, the physicians treating the woman finally attributed her lung condition to pesticide exposure. Nevertheless, this information did not improve her treatment options. The previous passage also shows how farmworkers often do not know the name of the chemicals used on the crops that they work with. The lack of this

information makes it even more difficult for a clinician treating farmworkers for pesticide- related ailments. The next case describes skin reactions to pesticide exposure.

Male Farmworker: The chemicals!

Female Farmworker: Oh and also those hives that appears!

Interviewer: What is this chemical called?

Male Farmworker: Those who work with lettuce, they spray and a fine dust remains. This dust gives those who work with lettuce severe infections in the eyes, problems with eyesight. It also gives them hives in the hands, a strong allergic reaction. You want to cut the leather off [of the gloves] until you reach the skin.

Female Farmworker: And so much itching. In Huron, California, I have noticed in Huron that they [the growers] use a strong chemical for a plant. We have a friend who took a razor, a knife to scrape the hives off his skin because of the itching from the allergic reaction. He went to the doctor and all, but they told him it was just an allergic reaction and that there was no cure. He would bathe three times at night because of the uncontrollable itching; he would scratch until it bled. He would try creams but nothing helped. I also have had an allergic reaction from the gloves that we use and all the dust, but all that remains is a blemish . . .

Interviewer: Do you still have this blemish?

Female Farmworker: No, it has gone away, these blemishes are mild, not noticeable. I don't have one now. But the hives stain the skin and make a person itch a lot. But it is only in the Huron area where I feel bad.

September 19, 1996 Spanish version in Appendix 2

This situation demonstrates the frustration farmworkers feel because of their allergic reactions often are not responsive to available treatments. These cases illustrate the need for specific biomedical research into the "everyday" allergic ailments that are attributed to pesticide exposure. Once again, the lack of knowledge of chemicals used is documented.

Pesticide poisonings in California receive notable attention from the media and public health officials. If a farmworker is poisoned by a pesticide exposure, this is usually a well-documented emergency and he or she should qualify for Workman's Compensation and Disability Insurance. However, it is the subtle allergic effects of pesticides from which farmworkers are more likely to suffer. While not life-threatening, these conditions cause a considerable amount of discomfort and pain. Nevertheless, these allergic reactions are often not recognized and treated as an occupational illness. Farmworkers with allergic symptoms have to rely on their own money or medical insurance to cover related medical problems that may arise form these allergic conditions. I now turn your attention to the observations made by Mecca Clinic staff.

Clinic Staff Observations

Clinic staff confirmed that farmworkers were often seen for the problems stated above. However, the doctors, nurses, and clinic laboratory staff also stated that the most common illnesses seen among farmworkers at the Mecca clinic were abnormal pap smears, anemia, depression, Chlamydia, diabetes, high triglyceride levels in the blood, and injuries related to on-the-job accidents. This research study was not designed to confirm the clinicians' observations or the self-reported histories of farmworkers interviewed in this study. However, a forthcoming publication by the *California Institute*

for Rural Studies of a 1999 statewide study of farmworkers should prove informative. Their study included a free physical examination for farmworkers and has the potential to confirm this self-reported qualitative data with strong quantitative clinical data.

Most farmworkers stated that they did not observe a difference between migrating and non-migrating farmworkers in the types of illnesses experienced. However, qualitative data obtained reveals subtle differences. The following section expands on this theme.

Medical Concerns Unique to Migrant Farmworker Households

As the following passages reveal, migration impacts health. Some of the health conditions revealed seem to be related to the type of migrant housing, while others are related to unfamiliarity with an area.

> *Interviewer:* What are the health problems that farmworkers experience?
>
> *Male Farmworker*: Health problems? For example, hygiene is very bad.
>
> *Female Farmworker*: The houses they give us are very dirty.
>
> *Male Farmworker*: The bathrooms and all this are dirty.
>
> *Female Farmworker*: The bathrooms are outside.
>
> *Interviewer:* Are they shared?
>
> *Male Farmworker*: The whole world does. And we get infections from them. I contracted a foot infection that I had to go all the way to Mexico to get it under control.
>
> *Female Farmworker*: It is very dirty there.
>
> *Male Farmworker*: But we continue working there.
>
> *September 18, 1996   Spanish version in Appendix 2*

Another farmworker was asked:

Interviewer: Do you think that migrating farmworkers have different problems than workers that remain in the same place?

Female Farmworker: Yes, because the migrant has more probability of getting sick because they keep traveling from one part to another. When they travel to a different part, it is more of a problem for them. Those who remain behind don' t have these problems because they are in their houses. When their work ends, they ask for unemployment, they have their food stamps so they can eat, and they are there doing well. For six months they are not going to have colds and other things. If they happen to get a fever or their molar tooth hurts or something else, they are there in their own house. But we, we are alone working.

September 24, 1996   Spanish version in Appendix 2

And finally this woman farmworker was asked:

Interviewer: When you are migrating for farm work, do you know where the health clinics are in the community?

Female Farmworker: No.

Interviewer: Do you know where the emergency room is when you work up there?

Female Farmworker: No. We just go there to work and that is it.

Interviewer: Do you know where you can buy medicine?

Female Farmworker: No, but I think we would just go to the store looking for the pharmacy.

Interviewer: When you are living up there, do you have problems with transportation when a member of your family needs to go to the doctor?

Female Farmworker: Why yes.

Interviewer: Why?

Female Farmworker: Because we only have one car, and he takes it to work with him. If one of the girls has to go to the doctor, we have to get permission from work to take them.

March 24, 1997 Spanish version in Appendix 2

Some migrating farmworkers stated that the experience of migration makes their families' more vulnerable to illness. One farmworker observed that her children experience more allergies, colds, and flu when they migrate. Some farmworkers also point out that the change in water and food puts their families at greater risk for stomach problems. In another example, one farmworker woman stated that when she migrated to Northern California, she and her family lived in a complex that housed six families. However, all six families had to share one toilet facility used by 50 to 60 adults and children. Still another farmworker pointed out that her children get lice when they are migrating for work. It appears that medical concerns unique to migrating farmworker households are in part due to poor, high-density housing situations with unsanitary conditions that lead to a greater risk of illness. In addition, farmworkers who migrate to a new location for the first time also may find it difficult to locate nearby medical faculties.

On the other hand, a small percentage of farmworkers interviewed in this study indicated that they did not have knowledge of nearby health facilities. Since most households had school age children, many had to take their children for health exams due

to school entrance requirements when migrating. This process acquainted farmworkers with nearby primary health care clinics.

Based on my observations, there are other health risks associated with migrating for agricultural work. In many households, diets change when they migrate. More specifically, it appears that the consumption of fast food and sugary junk food items increases when families are traveling for work. This change of diet can be attributed to the fact that, when both parents work there is little time left to prepare more nutritious homemade food.

Medical Concerns Unique to Non-Migrant Farmworker Households

Most farmworkers interviewed in this study stated that non-migrating farmworkers are not affected as much by illness. However, non-migrating farmworkers and their families also face unique health concerns. Non-migrating farmworker households do not have to deal with the rigors associated with frequent traveling. But due to poverty and the extreme heat of the homebase in Mecca, CA they also experience some important health concerns. The following interview passages with non-migrating farmworker reveal some of these tendencies.

> *Interviewer:* What are some of the health problems that you and your children face when you are not migrating?
>
> *Female Farmworker*: No more than colds, sometimes coughs.
>
> *February 22, 1997*

Another farmworker was asked:

> *Interviewer:* What health problems do you and your son have here in Mecca?
>
> *Female Farmworker*: Well, ... in the apartments.
>
> *Interviewer:* But what about your trailer?
>
> *Female Farmworker*: In the trailer right now it's the carpet. We have a leak where I wash the dishes and there is humidity and sometimes it provokes respiratory problems, this humidity. And then there is the heat, there is so much heat and then there is so much cold. There's the details, no more. Oh and sometimes there are other leaks?
>
> *Interviewer:* Leaks?
>
> *Female Farmworker*: For example, here if the gas isn't closed off very well, the gas leaks out.
>
> *Interviewer:* And you said there are health problems in the apartments?
>
> *Female Farmworker*: The paint in those apartments has lead. And another situation that I want to comment on deals with mosquitoes. We have problems with meningitis.
>
> *Interviewer:* Really?
>
> *Female Farmworker*: I don't know why, I don't know how, but the infant girl has bites from flies. She had meningitis when she was three months old. And they said that all the family had to get a medical exam. But we all had to pay. Some of them had Medi-Cal. My son doesn't have complete Medi-Cal and neither do I.
>
> *March 11, 1997 Spanish version in Appendix 2*

Non-migrating farmworkers who live in the harsh desert climate of Mecca work in an environment of heat and humidity during the summer months. Mecca is located near the polluted Salton Sea. During the summer, when humidity rises and temperatures rise to 120 degrees Fahrenheit, thousands of birds and fish die. This leaves a pungent odor that lingers well into the evening hours. In the extreme heat, insects multiply, creating further health risks. Non-migrating farmworkers state that during this time their family members suffer from heat exhaustion, skin problems, and respiratory ailments. Bug bites are also a constant source of irritation and seem to affect the children to a greater extent. Wild dogs are abundant, and the town has no drainage system to control water run off. Even though non-migrating farmworkers homebased in the desert may not have to deal with the hardships associated with migrating, it must also be pointed out that these farmworkers live year round in one of the poorest and most polluted rural areas in the United States. Non-migrant farmworkers in Mecca stated that they had problems with gas leaks, broken down refrigerators, non-functioning air conditioners, and unstable electrical connections. Life for those living in trailers and cars is uncomfortable because temperature changes from the extreme heat during and the day and to the cold of night.

Summary

At the heart of this study are distinctions between the migrating and non-migrating farmworker households homebased in desert southwest towns like Mecca, CA. Residents interviewed upstream at Art Ochoa followed a particular routine in Gilroy while simultaneously trying to maintain their homebase household. We have come to understand that this homebase location in Mecca is also an upstream location for mostly single migrant males homebased in Arizona or in the Mexican states bordering

California. For those homebased in Mecca, some work in the Coachella Valley year round, while other households migrate north during the extreme heat of summer. Despite the many challenges that these farmworkers face in their homebase and upstream residence, the majority of farmworkers in this study prided themselves on participating in an occupation that is a good honest day's work. Most acknowledge that the pay is low and the working conditions are harsh. Farmworkers are quick to understand the different labor structures that they work under as they switch from company to company. Many farmworkers will work six days a week and even double shifts during peak season. But during the off-season and the anticipated periods of unemployment, farmworkers plan vacations, medical procedures, and visits to distant relatives. They have developed a farmworker lifestyle that is typically characterized by intense periods of work followed some periods of unemployment. The farmworker lifestyle often revolves around the school schedule of their children. Moreover, farmworkers, especially women farmworkers, develop deep friendships in the fields. As one woman farmworker told me, "Gracias a Dios en el campo, me siento agusto! Yo soy feliz. Yo soy feliz y tranquila en el camp porque te encuentras con muchas amigas, muchos companeros, y pasas mas pronto el tiempo." Translated into English, she emphatically states, "Praise the Lord, in the fields, I feel very good. I am happy. I feel happy and peaceful working in the fields because I meet with many girlfriends, many companions, and the time goes by very rapidly." Most farmworkers do not want people to pity their harsh lives and they feel there is honor in the type of work that they are employed, despite the inherent hardships and injustices faced at the workplace.

Interviews with migrating and non-migrating households reveal that both groups of farmworkers experience a burden of heavy illness and disease. In this case study, migrating farmworkers traveled to a less polluted area than the homebase area studied. However, if migrating families end up in a substandard housing situation, the tendency to get sick increases. Non-migrating farmworkers, even those living in decent housing conditions, live in a harsh, impoverished, and polluted environment where illness is a constant companion. When I began this research, I expected that migrating farmworker households would experience a much greater illness burden. Instead, I found that both groups suffer from substantial health risks year round. The illness burden may be similar for these two groups; however, access to medical service differs. The next chapter examines potential and realized access to medical services.

CHAPTER 6: ACCESS TO MEDICAL SERVICES

Among agricultural laborers working in the United States, it is estimated that between 13 and 20 percent utilize health care services targeted towards them (Benavides-Vaello et al. 1994, Wilk 1986, Rust 1990). But why do so few farmworkers use these services and what does access to health care services really mean? There are several issues, covered in this chapter, related to potential and realized access to medical services that may help us address these questions. First, there is a discussion of *potential* access indicators: (1) farmworker knowledge of the geographic location of medical facilities, (2) medical programs targeted to low-income households, and (3) the varying degrees of medical insurance coverage by farmworker household members. Then factors that impact *realized* health care access, the utilization of medical services, are examined. These include self-reported barriers to medical services, as well as an examination of how current health policy regulations limit and facilitate access to medical services.

POTENTIAL ACCESS TO MEDICAL SERVICES

An important indicator of potential access to medical services is the actual location of medical facilities relative to where members of farmworker households live. In California, there are 17 Community and Migrant Health Centers that include more than 109 clinics serving farmworkers and other low-income residents. With the exception of some of California's more remote and sparsely populated northern counties, farmworkers interviewed in this study either live or work within a reasonable distance from at least one primary health care medical facility.

Farmworker Knowledge of Medical Facility Locations

Both qualitative and survey data collected for this research project indicate that both migrating and non-migrating farmworker households, more than 90 percent of the sample, knew where primary health care clinics and the nearest emergency rooms were located. The reason is probably that, in both research sites, the primary health care clinic was located in close proximity to where most farmworker households lived. In Mecca, there is a primary health care clinic run by Clinicas de Salud del Pueblo. In Gilroy, a Rota Care Free Clinic is located in the Art Ochoa Migrant Housing Center. However, it is important to point out that farmworker households that migrate into a new area for the first time have to learn where medical facilities are located. Nevertheless, access to a physical medical building for primary health care services for this sub-stream of farmworkers was possible.

On the other hand, nearby geographic access to treat emergencies or for tertiary medical care was not observed. In Riverside County, for example, farmworkers on the Medically Indigent Adults Program, Restricted Medi-Cal, or the uninsured were covered and treated locally only if the medical condition was what medical staff deemed life-threatening. If the condition was urgent, but not life-threatening, and the person was unable to pay for services or did not have private insurance, the patient was transferred from the Tenet-run JFK Hospital in Indio to Riverside Community Hospital in Moreno Valley. But this hospital is two hours away by car and almost five hours away by public transportation. For tertiary care, the closest facility is Desert Hospital in Palm Springs. However, farmworkers in this sample were sent to Loma Linda, San Diego Children's Hospital, and USC Medical Center in Los Angeles. All three of these facilities were

much farther away but treated the population studied at subsidized rates. Upstream, in Gilroy, CA, migrating farmworker households in this sample were treated at St. Louis Hospital or the Santa Clara Valley Medical Center. These hospitals are about a half-hour to an hour and a half away respectively.

The following excerpt illustrates the difficulties associated with transferring patients who need subsidized medical care.

Interviewer: Have you ever been denied medical attention?

Female Farmworker: Yes. At J.F.K it was right before we were sent to Riverside. We went to J.F.K because of a migraine and they said that because he did not receive Medi-Cal, that he could not be seen. And I said, because we didn't have money to pay? And that is when they sent us out of the emergency room and they sent us to Riverside. They told us to go to Riverside.

Interviewer: Was he eligible for Medi-Cal?

Female Farmworker: He had his permanent resident card; it is just that he did not receive it in the mail, but we had a letter. We were going through the whole thing [the immigration process]. And they would not give us Medi-Cal at the office because he did not have the actual card. That was the only thing that was holding him back, but he had the approval notice, he was just waiting for it in the mail.

Interviewer: So, in 1995, 1996 or 1997, did you encounter difficulties accessing medical services? I know it is repetitive.

Female Farmworker: Well yeah, at the time, that was the only time it happened at J.F.K, but other than that no.

Interviewer: Why do you think you were denied? ... J.F.K doesn't accept people without Medi-Cal?

Female Farmworker: I think it is because, to get people to pay. But they should offer some kind of service before sending you 2 hours away to Riverside.

Interviewer: I wonder what would have happened in an emergency, I guess law would have treated him...?

Female Farmworker: Yeah, in an extreme emergency, but my husband's migraine wasn't thought of as an emergency. But it was [an emergency] to <u>me</u> and it was to <u>him</u>. And it was-- his migraines were caused from pork meat, a virus in his brain, and I think that is an emergency and the nurses didn't even give him a diagnostic check. They didn't check what was causing the migraine, nothing.

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In this case, an English-speaking wife of a farmworker was recollecting how her husband was transferred from the closest emergency room to one that was two hours away. This case demonstrates that failure to show the actual card proving California residency prevented this male farmworker from receiving presumptive emergency Medi-Cal at this facility. Moreover, this case demonstrates how urgent problems are dealt with if one does not show proof of ability to pay. Later, at the second hospital in Riverside, his headache was attributed to a virus in his brain. Although she could not remember the formal diagnosis, this could have been a food-related incident. Handling this case locally could have alerted local doctors of this problem in other patients and made things a lot easier for this family.

In summary, for this sub-sample of farmworkers, both migrating and non-migrating farmworkers experienced a similar high level of potential access to basic primary health care services and for treatment of life threatening emergencies. However, potential access for urgent medical problems and tertiary medical services remains limited for those with low-income, the uninsured, and recipients of restricted public benefits homebased in the desert Southwest.

Another strong indicator of potential access to medical services for farmworker households is the availability of medical care programs at low cost. The following section elaborates on the public, private, and charity programs available to low-income Californians. A brief discussion of each of the programs' requirements demonstrates the potential for members of farmworker households to use these services.

Public, Private, and Charity Health Programs for Californians

It is often assumed that the only health program available in California for low-income residents is the subsidized public Medi-Cal program, which is the state name for the federally sponsored Medicaid program. Nevertheless, this research effort has uncovered a variety of public, private, and charity health programs designed for low-income Californians. The next several pages describe some of the programs, listed in alphabetical order, targeted to specific groups of Californians.

ACCESS FOR INFANTS AND MOTHERS (AIM)

Access For Infants and Mothers is a low-cost medical insurance designed for moderate-income, California-resident pregnant women whose household income ranges from $21,701 to $66,150, depending on family size. This program strives to offer affordable health insurance by selected commercial health plans and is subsidized by the

State of California. AIM includes complete medical coverage during pregnancy, hospital delivery, and postpartum care for 60 days, complete services for the baby up to his or her second birthday, and pharmacy costs. The total cost of the medical insurance to the pregnant woman is two percent of her gross annual household income. There are no co-payments and no deductibles to meet. To be eligible, a woman applies for the program before her thirtieth week of pregnancy (seven and a half) months. Moreover, she must be either uninsured or have a separate maternity deductible or co-payment greater than $500. A woman must also be a California resident for six months and not eligible for no-cost Medi-Cal or Medicare benefits. In order to enroll in the program, a woman is encouraged to contact an AIM outreach worker. In the Los Angeles area, the phone number is (213) 538-0755. In San Diego and Imperial Counties, the phone number is (619) 492-4422. In Northern and Central California, there are two toll-free numbers that can provide assistance: 1 (800) 300-1031 or 1 (800) 433 2611. The statewide toll-free number is also 1 (800) 433-2611 (State of California, Health Families Application and Certification Training Manual 1998). None of the farmworkers interviewed in this study reported being enrolled in this program. Farmworkers in this study did not meet the higher income requirements that start at $21,701. The advantage of the AIM program is that women who are sponsored, California-resident immigrants can apply without having to worry about whether or not they will be considered a public charge. Therefore, higher- income farmworker women, such as mayordomas, irrigation specialists, and those with permanent, full-time employment in packinghouses may qualify for this program. This program should be more aggressively marketed in areas where high concentrations of

non-migrating farmworker households live, such as the homebase community of Mecca, CA.

ADOLESCENT FAMILY LIFE PROGRAM (AFLP)

The target groups for this program are pregnant and parenting teens 17 years and under. The budget of the Adolescent Family Life Program was approximately $19.7 million dollars for fiscal year 1996-1997. There is no specific income requirement. Riverside County and, more specifically, the Coachella Valley continue to have the highest teenage pregnancy rates in California. Adolescent Family Life Program funds are utilized in local programs such as Bright Futures that are based in the Coachella Valley School District. The programs that these funds support educate adolescents. In the Mecca area, it remains difficult to retain the qualified staff needed to run the programs that these funds support. For more information, the telephone number listed is (916) 657-3064, which is the California Department of Health Services. They also have a web site at http://www.dhs.cahwnet.gov. When I called the phone number, I was referred to the Maternal and Child Health Branch. The phone number for this branch is (916) 657-4686 (State of California, Health Families Application and Certification Training Manual 1998). One possible beneficial use of these funds would be to train community health workers specifically to mentor these young parents and other at-risk youth. In Mecca, there are reports of pregnant eighth graders each year. This means that these girls are becoming pregnant at age 12 or 13. As of 1999, there is no direct outreach to these teens. Special attention needs to be paid to the Terrascan-speaking youth in Mecca. Terrascan-speaking youth are more likely to become parents below the age of 15.

BABYCAL CAMPAIGN

The target group for this program is all pregnant women in California. It is primarily a public awareness campaign. The BabyCal program established a toll-free hotline (1 (800) BABY 999) that women may call for referrals for prenatal care and other support programs. In Mecca, the BabyCal program sent the Mecca clinic prenatal gift packets for those receiving pre-natal care under the Medi-Cal program. These packets included a tote bag, a health diary, and some trial samples of baby products. BabyCal posters on buses and other public places encourage expectant women to call the toll-free number listed above to seek medical services (State of California, Health Families Application and Certification Training Manual 1998).

CALIFORNIA BLACK INFANT HEALTH PROGRAM

Four million dollars in state funding have been allocated for this program that targets African-American infants and families. This program offers family support to reduce the rates of infant mortality in African-American babies. This is essentially a fund to which health care programs in 16 health jurisdictions can apply for supplemental funding if they serve African-American women and children. This program because in that Community and Migrant Health Centers in these jurisdictions also serve other low-income residents. If clinic management can apply for some of these funds to cover pre-natal and other pregnancy related services for their African-American clients, then other clinic resources can be directed to cover uncompensated care for other clients. Furthermore, in California, there are some African-American farmworkers who labor in the watermelon fields in Imperial County (State of California, Health Families Application and Certification Training Manual 1998).

CALIFORNIA'S CHILD HEALTH AND DISABILTY PREVENTION PROGRAM (CHDP)

The target group for this program includes infants, children, and youths from birth to age 19, young adults ages 19 and 20, and enrollees in Head Start and State Preschools. To meet the income test for this program, a family's income must be at or below 200 percent of the Federal Poverty Level, or the family must receive Medi-Cal. Children who qualify for CHDP Health Assessments receive the following periodic preventative health examinations: health and developmental history, physical examination, nutritional assessment, immunization, vision testing, hearing testing, lead testing, specific laboratory testing (tuberculin, sickle cell, urinalysis, hemoglobin/hematocrit, Pap spears), and preventative dental care exams for children under three years of age. California's Child Health and Disability Prevention Program is guided by regulations from the federal Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). CHDP exams play a large role at the Mecca Clinic. Most of the children of farmworkers are eligible for these free exams, and these families take advantage of this program, especially in the months of August and September, in order to meet school health requirements. Since the implementation of the new Immigration Law in August 22, 1996, parents who are sponsored immigrants have been afraid to take their children to these free exams out of fears that they will be designated as public charges. However, according state administrators, eligibility is based on self-reported income only and not on documentation status. Children do not have to be citizens in order to qualify for this program. Unlike the Med-Cal program, the application process is simple-- no proof of income or documentation status is required. You just need to prove that you are a resident of the county that you are applying to. The statewide number for the Children's Medical Branch that administers this program is (916) 654-0832 (State of California, Health

Families Application and Certification Training Manual 1998). The application process is easy enough for migrating farmworker households and there is great potential for children of farmworker households to utilize these programs.

CALIFORNIA CHILDREN SERVICES (CCS)

Children under 21 years old who have a specific qualifying physical limitation or disease can apply for this program. Family income must be less than $40,000 and out-of-pocket expenses for the qualifying child are expected to be more than 20 percent of the family income. The CCS program treats children with specific diseases. These children are often permanently disabled, and the application process is detailed and covers what Medi-Cal does not. The applicant only has to provide two items that prove county residency– usually rent and utility bills. Children who are American citizens, permanent residents, or even undocumented qualify for CCS if they also meet the income and medical requirements. Children who are present in the United States on some type of visa do not qualify for this program since they are only temporary residents. There are CCS offices in most counties. In Santa Clara County, the local number is (408) 299-5891, and in Riverside County the local number is (909) 358-5401 (State of California, Health Families Application and Certification Training Manual 1998). In this study, a few children from non-migrating households were benefiting from the services of this program. Children on CCS usually have rare and severe disorders that are permanent. These children are usually in wheelchairs or require other types of orthopedic devices. In this study, mothers of children on this program in this study were pleased that they were able to get their children the special equipment needed, often free of cost. However, these mothers also pointed out that living in a remote rural area puts their child at a

disadvantage since services are usually a great distance from where they live. In addition, it is sometimes very difficult to get what the parents see as an adequate amount of physical and occupational therapy for the their child, in addition to the respite care that gives the parents a needed break.

CALIFORNIA KIDS

California Kids is a program that provides preventative and primary health care for uninsured children regardless of legal status. In order to qualify for this program, a child must be ineligible for Medi-Cal and the Health Families Program. Children between the ages of two and 18 are eligible as long as they are not married and they remain in school. Each child in the family must be enrolled in California Kids if the family qualifies, and a minimal charge is required for prescription drugs and doctor's visits. Medical services which are covered include routine physical exams and immunizations, doctor's visits when the child requires urgent medical attention, diagnostic laboratory tests including x-rays, some emergency medical and accident care, same-day surgery, vision and dental services, mental health care, and 24-hour telephone service. This program does not cover inpatient specialty hospitalization. Their information telephone number is 1 (800) 374-4543.

Upon the approval of a county-designated public health nurse, uninsured children can receive free or low-cost medical treatment for urgent medical programs. Each county program is run differently, and this is a private charity program (State of California, Health Families Application and Certification Training Manual 1998).

CALIFORNIA SCHOOL HEALTH SERVICES

In California, there are more than 60 school-based health care centers that operate out of elementary, middle, and high schools. Mecca Elementary School is one such school that receives funds to provide limited medical services to both parents and children. Most School Health Centers offer the following health services: physical exams, vaccinations, treatment of minor illnesses and injuries, counseling, treatment of substance abuse problems, health education, reproductive services in high schools, and referral to specialists. Children are eligible for services after parents sign a permission form. There is usually no charge for the services. However, the school may bill the child's private medical or public medical plan. At the Mecca Elementary School, funds from the California School Health Services Program supplement the Health Families Grant. Together, these two programs provide general physicals, eye exams, and dental exams for children. In Mecca during the 1998 school year, both children and parents were also offered diabetes testing (State of California, Health Families Application and Certification Training Manual 1998).

CHILD CARE AND DEVELOPMENT PROGRAM

This program funds several types of initiatives that lead to the development of more day care options for low-income families. This program, which is a mixture of state and federal funds, had a budget of $999.480 million dollars in 1997. The Child Care and Development Program sponsors centers and networks of family child-care homes. They are operated by either a private or public agency, for the provision of child-care services from infancy through age 13. Specific programs that receive funding include State Pre-School; General Child Care; Campus Migrant, School-Age Parenting; and Infant

Development; Handicapped, Family Child Care; and Latchkey. In Mecca during 1998, approximately 40 women received the training needed to operate state-licensed day-care programs in their homes. In Mecca, at least seven separate, subsidized day-care programs exist for children of migrant farmworker households, and they serve about 200 children. Each program has long waiting lists. Moreover, it is difficult for both the Migrant program and the school district to retain qualified bi-lingual day-care teachers to work in this isolated rural location. Nevertheless, although there has been funding for day-care initiatives throughout California, and some has even reached Mecca, the need far surpasses the demands (State of California, Health Families Application and Certification Training Manual 1998).

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

CPSP is actually a Medi-Cal program, so only Medi-Cal recipients are eligible. CPSP participants receive case-managed pregnancy and postpartum care from conception to 60 days after birth. Women with high-risk pregnancies are especially encouraged to take advantage of this program. A large part of this program involves referring these women to other programs that can complement and enhance the services they receive through CPSP. These referred programs include the Women, Infants, and Children Supplemental Food Program (WIC), Genetic Screening, Dental Care, Family Planning, and the Child Health and Disability Prevention Program. Since referrals to this program are confidential and part of the Medi-Cal pregnancy pre-natal visits, I do not have information about whether members of farmworker households took advantage of this program (State of California, Health Families Application and Certification Training Manual 1998).

DISABILITY INSURANCE

Disability Insurance is administered in California by the Employment Development Department. If a farmworker qualifies for unemployment benefits, then Disability Insurance, a program completely financed by contributions from the employee and his or her employer, usually covers him or her. In this study, I only encountered one farmworker who was trying to obtain this coverage. In general, some farmworkers are covered by this insurance if they are injured on the job, but temporary agricultural workers usually are not covered. Since 60 percent of the farmworkers in this study reported receiving unemployment benefits, we can infer that a similar portion of farmworkers in this study would also qualify for EDD disability insurance if they were injured on the job.

FAMILY PLANNING, ACCESS, CARE & TREATMENT (FAMILY P.A.C.T.)

Family P.A.C.T. is a program designed to provide comprehensive family planning services to low-income men and women. Low-income men and women qualify for this program as long as their income is at or below 200 percent of the Federal poverty level. This is a relatively new state-funded program that began in 1996. This program provides all FDA-approved methods of contraception, pregnancy testing, male and female sterilization, some infertility services, sexually-transmitted-diseases testing and treatment, HIV testing, pap smears, dyplasia services, and other forms of reproductive health education and counseling. This program pays for many medical visits at the Mecca Clinic since enrollment is simple. Clinic staff members determine if the person seeking services is a resident of the county. A short application is filled out at the provider's office, it is activated instantly on-site, and newly enrolled patients leave with a client benefit card the

same day. The information telephone lines for this program are (916) 654-0357 and (800) 942-1054 (State of California, Health Families Application and Certification Training Manual 1998).

FOOD STAMPS

During the course of this research, the laws regarding whether or not non-citizen immigrants are eligible for food stamps in California has changed several times. The Food Stamp Program is a federally sponsored program that has gone through dramatic changes due to the passing of the Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 and the Illegal Immigration Reform and Immigration Responsibility Act of 1996. Essentially, these laws eliminated food stamps for most non-citizens, which would include members of farmworker households. In 1998, benefits were restored at the federal level to elderly, disabled, and immigrant children. As of November 1999, federal legislation is pending which would restore food stamps to other immigrants who lost eligibility due to the 1996 laws. However, at the state level, states can choose to provide food stamps to immigrants made ineligible by federal law if funds are allocated for this purpose. California legislators, in response to these federal statutes, have chosen to provide state-funded food stamps to most immigrants. In addition, two million dollars was allocated for nutritional assistance programs to legal-immigrant migrant farmworkers (State Action on Immigrant Food Assistance 11/29/1999). Only 22 percent of the households sampled in this study reported using the Food Stamps Program during 1997. Despite efforts to restore food stamps to all immigrants, it is currently very confusing to figure out which immigrants can receive this benefit. As of this writing,

undocumented persons do not qualify for the Food Stamp Program. They may, however, qualify for emergency nutritional support programs.

HEAD START

Head Start is a federally funded national program that provides pre-school, medical and dental services, nutritional programs, and mental health services for low-income children from birth until entry into elementary school. Head Start for farmworker children is called Migrant Head Start and is extremely popular in Mecca. The waiting lists are long due to high demand. Further information on this program can be obtained by calling (916) 323-5089 or (916) 323-1342 (State of California, Health Families Application and Certification Training Manual 1998).

HEALTHY START SUPPORT SERVICES FOR CHILDREN ACT

In a school district that has a Healthy Start Program, which is true in the case of Mecca, free medical and dental exams are offered to all children enrolled in the local elementary school. The goal of the Healthy Start program is to provide integrated service delivery by case managing at-risk families. Healthy Start attempts to meet the needs to families by offering family support in the form of parent education and child-care. Another area of concern is meeting basic needs, such as food, clothing, shelter, and transportation. In Mecca, Healthy Start provided holiday food baskets and vouchers to the Salvation Army. Healthy Start personnel also organize programs designed to address medical needs of the community. In Mecca, Healthy Start coordinated free medical exams, eye exams, hearing exams, and dental exams through local agencies that could donate these services. Other goals of the Healthy Start programs include mental health counseling, tutoring, employment counseling, after school programs, and linkage to

welfare services. Healthy Start is operated by the California Department of Education and local school districts. To accomplish its goals, close collaboration, cooperation, and agreement are needed from local school officials. Due to bureaucratic constraints, this is not always easy to accomplish. However, in the Mecca area, the Healthy Start Program sponsors monthly meetings that bring a variety of local social service agencies together. This communication in itself is very productive (State of California, Health Families Application and Certification Training Manual 1998).

HEALTH INSURANCE PLAN OF CALIFORNIA

This program, which has no income test, is designed for employees of small businesses and their dependents. The main focus of this program is to pool small businesses so they can obtain more affordable coverage for a small number of employees through volume purchasing of medical insurance programs. This program could benefit farmworkers if labor contractors where to take advantage of this effort. More information can be obtained by calling (800) HIPC-YES or (916) 324-4695 (State of California, Health Families Application and Certification Training Manual 1998).

IMSS MEXICAN INSURANCE

In Mexico, IMSS/Instituto Mexicano del Seguro Social covers 40 million people and is financed by the Mexican Federal Government and by employee contributions. However, IMSS is reaching out to Mexican Nationals and Mexican Americans living in the United States. For $307 dollars per year, members of Mexican-origin households living in the United States can receive services at IMSS affiliated hospitals, clinics, day-care centers, and community centers throughout Mexico. Visits to physicians, hospitalization, major surgery, childbirth and maternity benefits, labs and x-rays, and

prescriptions are covered. The following pre-existing conditions are not covered– cancer, HIV infection, and complications resulting from diabetes. There are no deductibles to pay. IMSS maintains three offices in the United States– Houston, Los Angeles, and Chicago. IMSS can be reached at (888) 202-2720 or by way of email at imssamigos@aol.com.

KAISER PERMANENTE CARES FOR KIDS

Kaiser Permanente Cares For Kids is a non-profit, tax-exempt organization that was established in 1997 to ensure health insurance coverage for the approximately 1,700,800 children who are uninsured in California. Uninsured school-age children whose family income is above 200 percent but not above 275 percent of the Federal poverty level are eligible for this comprehensive medical insurance program. In other words, subsidized coverage is offered for children from families who make up to $68,000 in household income. Nevertheless, this is not free coverage since parents pay a monthly fee of $25-$35 per month per child. Children must be California residents, but undocumented children are not excluded from this program. And, parents who apply to this program must submit tax returns that claim the children as their dependents. This program is also linked with the *Health Insurance Plan of California* in order to provide subsidized coverage to uninsured children from working families. Children of farmworkers can benefit from this program if they live near a Kaiser facility. For children in Mecca, the closest Kaiser facility is more than two hours away. However, children of farmworkers living in the Art Ochoa Migrant Center in Gilroy live less than a mile from a Kaiser clinic. Even though the monthly premium is capped at a maximum of $75 per month per eligible family, it is still very expensive for farmworker households. This

program, however, could benefit a family who has a child with a chronic medical condition requiring specialized and costly medical treatment. It is important to note that Kaiser will only enroll 50,000 children per year. Moreover, this program will end on December 31, 2002. More information on this program can be obtained by calling (800) 255-5053 (State of California, Health Families Application and Certification Training Manual 1998).

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP)

This state program, which has a long waiting list, provides coverage for individuals who are unable to obtain coverage on the open market due to reasons other than non-payment of premiums. For example, this program provides coverage for Californians who have been previously denied medical coverage due to pre-existing medical conditions. The benefit package is comprehensive but the premium is equal to 125 percent of the standard average individual rate. There is also a maximum program benefit of $50,000 per year and a $500,000 cap on lifetime coverage. This program is designed for people who have severe chronic medical conditions who do not qualify for any other type of coverage. An uninsured member of a farmworker household who is very sick may benefit from this program. For example, if a person has an aggressive type of curable cancer, the cost of the program may be well worth the life-saving treatment since paying for cancer treatment completely out of pocket is out of reach for most farmworkers. Information on this program can be obtained by calling (800) 289-6574 (State of California, Health Families Application and Certification Training Manual 1998).

MATERNAL AND CHILD HEALTH

California requires that all health jurisdictions have a toll-free telephone services for maternal and child health services. In Riverside County the number is (800) 794 4814, and in Santa Clara County the number is (800) 310-2332 (Department of Health Services: Health Families Handbook 1998).

MEDI-CAL: CALIFORNIA'S MEDICAID PROGRAM

Medi-Cal is a subsidized medical insurance that encompasses a huge consortium of various programs providing medical services for low-income residents, the elderly, and the disabled. Medi-Cal is California's Medicaid program and is funded with approximately 10 billion dollars in federal funds and 10 billion dollars in California state funds. Five-million-one-hundred-thousand California residents, approximately 16 percent of the state population, receive Medi-Cal benefits, and it is administered by the California Department of Health and Human Services (Medi-Cal Policy Institute 1998). As of July 1998, 157, 239 Medi-Cal recipients received benefits in Santa Clara County totaling $414,229,601 million dollars. In Riverside County, 199,075 persons received Medi-Cal benefits totaling $357,650,124 million dollars (Medi-Cal Policy Institute July 1999).

For a person to become eligible for Medi-Cal, he or she must complete a very detailed application process and meet property, income, institutional, residence, and citizenship requirements (Medi-Cal Policy Institute July 1999). Programs funded with Medi-Cal funds include Medically Indigent Programs; Medically Needy Programs; Health Families Program; Transitional Medi-Cal for CalWorks recipient; Fee-for-Service Medi-Cal; and Managed Care Medi-Cal. In fact, there are 107 categories in which a person can qualify for Medi-Cal benefits.

Relevant to this research is whether or not non-citizen members of farmworker households can qualify for Medi-Cal benefits. During the course of this study, the laws regarding immigrant eligibility have changed several times. When I began interviewing farmworkers, most non-citizen farmworkers were made ineligible for Medicaid benefits due to the passing of federal legislation in 1996. In addition, anti-immigrant legislation in the form of California's proposition 187 put further restrictions on access to publicly subsidized medical services, including pre-natal care. However, in 1998 and 1999 many of these restrictions have been lifted due to passing of California state-sponsored bills designed to circumvent some of the federal restrictions. As of November 1999, most California legal residents can apply and receive Medi-Cal benefits as long as they meet the specific income requirements. Moreover, undocumented persons can now receive subsidized emergency care and pre-natal care. In addition, sponsored immigrants no longer need to worry about public charge legislation when applying for most Medi-Cal programs. Despite this improved climate for subsidized immigrant health care, the perception at the local level is that non-citizens still do not qualify for these benefits. In this research, 15 percent of the women, 12 percent of the men, 67 percent of the children reported having some form of Medicaid. Since most of the members of the households interviewed meet the federal poverty level guidelines, more of the adults and children in this sample should have been eligible for Medi-Cal benefits. It is my impression that Medicaid programs are underutilized by members of farmworker households because there is widespread confusion on who qualifies for these programs.

PARTNERSHIP FOR RESPONSIBLE PARENTING

Begun in 1996, this program is essentially educational, designed to reduce the number of teenage pregnancies in California. As part of this program, 53.6 million dollars for Community Challenge Grants were awarded to public and private community based groups that work to prevent teen pregnancy. In the Coachella Valley, there are a number of programs that are eligible for these funds. However, reaching adolescent girls in Mecca continues to be a difficult task for these types of efforts. Two other aspects of this program include a Media Campaign and increased Statutory Rape enforcement. Statewide, the media program was allocated a budget of 30 million dollars. The media campaign has reached Mecca and advertisements about teenage pregnancy can be found on the buses, television, radio, and in the clinics.

Enforcement of California's Statutory Rape laws is enhanced by an additional $8,400,000 statewide. This punitive aspect of the program is apparent in the Coachella Valley and has caused some problems for members of farmworker households. For example, if a woman under 18 is pregnant, there is a strong effort to find out who the father is in order to prosecute him. If the district attorney decides to prosecute the case, it will be done even if the pregnant person does not want this to happen. This effort has instilled utter fear in these young women and they are thus afraid to seek pre-natal care. Among the Tarascan people in Mecca, it is not uncommon for young women to give birth to their first child before the age of 15. As a community health worker, I have seen first hand several girls pregnant at 13 and 14 years of age. They delay seeking pre-natal care because several Terrascan men have been jailed for statutory rape. In addition, they are also fearful that their infants will be taken away from them due to recent interventions

from Child Protective Services. Essentially, the statutory rape enforcement in the Mecca area is culturally inappropriate because the Tarascan people are accustomed to starting families at very young ages. Other local community-based efforts are needed to reduce this high rate of teenage pregnancy among non-Spanish and non-English speaking peoples from rural Mexico participating in California's agricultural labor force.

The final part of this program is funding of 10.6 million dollars for a teen mentor program. I have not seen this aspect of the program implemented in the Mecca area (State of California, Health Families Application and Certification Training Manual 1998).

ROTACARE PROGRAM

The RotaCare program provides free medical services for migrant farmworkers at the Art Ochoa Migrant Housing Center in Gilroy, CA. RotaCare Free Clinics began in 1989 by Rotary Club members in Morgan Hill, CA (Bureau of Primary Health Care 1996). This program targets the homeless, migrant workers, and immigrant populations who are either uninsured or underinsured. In addition to the primary health care services provided, local referrals to social service agencies link clients to programs that can also address other needs. Clinics operate two to three hours once a week and usually see between 15 and 40 patients in a given session. The cost "to operate a clinic for one year is between $15,000 and $20,000 at a per patient cost of approximately $16 to $19, including medications"(Bureau of Primary Health Care 1996). Volunteers who staff the clinic at Art Ochoa usually work for six to eight weeks. Farmworkers interviewed at Art Ochoa appreciated this program. However, farmworkers pointed out that services could be improved if they were open more hours, volunteers served longer terms, and more clinic

staff were bi-lingual. More information on this program can be obtained by calling (408) 683-2402.

WOMEN, INFANTS, AND CHILDREN SUPPLEMENTAL NUTRITION PROGRAM (WIC)

The WIC program is well known among members of farmworker households. WIC is a federally funded program, and even undocumented women and children can receive WIC benefits. The target groups for this program are women, infants, and children up to five years old. Low-income and moderate-income families may be eligible for this program. Essentially WIC is a comprehensive nutrition program with the goal of preventing hunger and malnutrition among vulnerable low-income families. These benefits include food vouchers, breast feeding information, and referrals for medical care. Special checks, called food vouchers, are issued to qualifying families and enable these households to obtain the following foods at no cost: milk, juice, eggs, cheese, cereal, dry peas and beans, and peanut butter. Further information on this program can be obtained by calling 888-942-9675. WIC provides nutrition education, breastfeeding support, and coupons for nutrition services (State of California, Health Families Application and Certification Training Manual 1998).

WORKMAN'S COMPENSATION

By law, most farmworkers should be eligible for Workman's Compensation Insurance if it can be proved that an injury occurred at work. All medical services should be completely paid for. A few farmworkers interviewed in this study had received some form of Workman's Compensation benefits. Navigating the California Workman's Compensation system and obtaining information on how many agricultural workers apply and receive workman's compensation services is difficult. In California, the toll free information telephone number is (800) 736-7401. District Offices relevant to

farmworkers in this study are located in San Jose at (408) 277-1292 and Riverside (909) 782-4347.

Members of farmworker households, if given the correct information and referrals, can potentially utilize a variety of public, private, and charity programs targeted towards them and other low-income California residents. Before examining the intricacies of the various programs described in the above section, it is useful to look at what types of medical insurance coverage were reported by heads of households interviewed in this study.

Medical Insurance Coverage by Household Members

Medical insurance coverage for members of farmworker households in this study can be divided into the following categories: public insurance, employee-based private insurance, a mixture of both public and private plans, and Mexican medical insurance.

Despite the numerous studies on farmworkers, there is still little information on the types of medical insurance coverage among farmworker households. In California, there are a few studies under way that estimate the percentage of medical insurance coverage among California farmworkers and their dependents. Two small community research studies, the McFarland Child Health Screening Survey and the Parlier Health Survey, can give us some idea as to health insurance coverage among members of California farmworker households (Villarejo 1999). In McFarland CA the Department of Health Services attempted to screen every family who had a child between one and twelve years old. One-thousand-six-hundred-ninety-seven children were screened, which was 90 percent of the eligible population. In this survey, 54 percent of the families interviewed reported some type of medical insurance coverage– 32 percent private

insurance and 22 percent Medicaid (Villarejo 1999). In the Parlier study, 39 percent of the families interviewed reported some type of medical insurance coverage– 25 percent private insurance and 14 percent Medicaid (Villarejo 1999). The National Agricultural Workers Survey reports that 32 percent of farmworkers in California have some type of employee-based medical insurance (Rosenburg et al. 1998). As a matter of further comparison, according to the 1989 National Health Interview Survey, 58 percent of Latinos, 85 percent of Anglos, 82 percent of African-Americans, and 81 percent of Asians and Others, report having some type of medical insurance coverage in California. Latinos in California, according to this survey, have the highest uninsured rate of any ethnic group (Wyn et al. 1993).

In this sample of farmworker households living in subsidized housing, 79 of the 130 women (61 percent), 74 of the 108 men (69 percent), and 214 of the 322 children under 18 (66 percent) reported having some type of insurance at the time of the interview. It is useful to describe the type of insurance reported.

Public Insurance

In this sample, 19 of the 130 women (15 percent), 13 of the 108 men (12 percent), and 216 of the 322 children under 18 (67 percent) reported having one of the following public medical insurance programs: listed below. The following public medical insurance programs were reported by farmworkers: Access, California Children Services, Child Health and Disability Prevention, MediCal and Medically Indigent Adults, Medicare, SSI, and Workman's Compensation. Most qualified for programs based in California. However, a few migrating farmworkers homebased in Arizona also qualified for Arizona's Medicaid program, Access, when they lived there.

Most farmworkers and their dependents in this population qualify for public programs, such as Medi-Cal and county-administered Medically Indigent Adult (MIA) programs. Even undocumented pregnant women, undocumented adult farmworkers, and undocumented children still qualify for restricted Medi-Cal. The key is that they need to apply before the emergency happens. Otherwise, retroactive Medi-Cal coverage must be approved; if it is not, they will receive expensive medical bills. Research findings indicate that knowledge of these available public programs is limited among this population. I now turn your attention to employee-based medical insurance.

Employee-Based Medical Insurance

In this sample, 49 of the 130 women (38 percent), 52 of the 108 men (48 percent), and 90 of the 322 children under 18 (28 percent) reported having private employee-based medical insurance.

Most farm laborers in this sample have a modest private medical insurance plan that has high deductibles ($250-$500), a cap on coverage ($5000), and restrictions on approved providers. Those with private insurance have many concerns and access issues that affected their overall use patterns. This will be discussed in subsequent sections. I now turn your attention to coverage in Mexico and Mexican medical insurance.

Coverage in Mexico and Mexican Medical Insurance

More than 80 percent of the heads of household interviewed reported traveling to Mexico to purchase medications, seek medical or dental care, or use the services of traditional medical practioners. Most of them paid out of pocket for services rendered. However, a small percentage of farmworkers went to Mexico for services because their US employee-based private insurance covered 100 percent of their medical expenses.

More specifically, at least four insurance companies– Transwestern, Western Growers, United Agriculture, and Robert F. Kennedy– will pay for full coverage if the farmworker goes to Mexico for medical services. This sometimes includes coverage for labs and medicines. Both migrating and non-migrating farmworkers appreciate this benefit.

Furthermore, one woman farmworker reported having IMSS insurance offered by the Mexican government. Although the data from this sample do not demonstrate it, the Mexican government is increasingly trying to convince Mexican nationals living and working abroad to purchase Mexican health insurance that can be utilized when they visit Mexico. Future studies may reveal more information regarding the extent to which Mexican health insurance is used by farmworkers in the United States. Despite the low utilization of this medical insurance plan by farmworkers in this sample, there is still great potential for farmworkers to apply for this program. The reality, however, is that most farmworkers simply do not know that this option exists.

Uninsured Farmworkers

In this sample, 51 of the 130 women (39.2 percent), 34 of the 108 men (31 percent), and 108 of the 322 children under 18 (33.5 percent) reported having no insurance at the time of the interview, although they might have had insurance at some point during the previous year. As a matter of comparison, 42 percent of Latinos under the age of 65 are uninsured in California (Wyn et al. 1993). Those without insurance either did not seek services, paid out of pocket, or relied on the occasional free exams offered through schools, shopping malls, or health fairs. It is important to point out that most low income farmworkers, even if they are undocumented or do not have medical insurance, generally will qualify for Limited Scope MediCal, otherwise known as

Emergency or Restricted MediCal, in a life threatening emergency or for the delivery of a child. In this study, four of the 130 women (3 percent), four of the 108 men (4 percent), and 17 of the 322 children under 18 (5.2 percent) utilized this restricted public medical insurance. In short, out of 560 farmworkers and their dependents, only 25 persons (4 percent) used this restricted, but often expensive, program for coverage of emergency medical expenses. So the argument that immigrant farmworkers are burdening public hospitals with expensive and uncompensated care is not substantiated from the data collected for this research project.

Important to this research project is whether or not migration status affects the type of medical insurance coverage of farmworker household members. More specifically, insurance type was collapsed into those with "no insurance" as opposed to those with "some type of insurance." Three separate chi-square tests of independence were calculated comparing migration and type of insurance coverage for men, women, and children in this sample. Figure 6.1 illustrates the results.

Figure 6.1: Chi-Square Analyses of Insurance and Migration

	M	NM	Total	Pearson Chi-Square	DF	Significance
Women:						
No Insurance	28	23	51			
Some Insurance	47	32	79	.268	1	NS
Total	75	55	130			
Men						
No Insurance	21	13	34			
Some Insurance	46	28	74	.002	1	NS
Total	67	41	108			
Children						
No Insurance	60	48	108			
Some Insurance	139	75	214			
Total	199	123	322	2.685	1	NS

Even collapsing the insurance type into the two categories, no significant interaction was found between migration and insurance type for women, men, or children– chi-square (1) = .268, $p > .05$; men: chi-square (1) = .002, $p > .05$); or children: chi-square (1) = 2.685, $p > .05$. In summary, it appears that at alpha .05, the chi-square values of .268, .002, and 2.685, with 1 degree of freedom, migration status does not impact the type of insurance coverage reported by members of farmworker households.

Examining Potential Access to Medical Services

Potential access to medical services was examined in this study by (1) analyzing knowledge of the geographic location of medical facilities, (2) uncovering medical programs targeted to low-income households, and (3) finding out the varying degrees of medical insurance coverage by farmworker household members. This study turned up a few revelations. As for the geographic location of medical facilities, California appears to have a decent number of primary health care facilities available to rural residents. On the contrary, access to emergency care, urgent care, and tertiary care is more difficult for rural residents because of the distance needed to travel to obtain these services.

By means of my interviews with farmworkers, my training as a community health worker, and a comprehensive literature search, I was able to uncover a variety of medical programs available to low-income California residents. Overall, members of farmworker households have the potential to use a variety of medical programs that are targeted to other low-income Californians. Some programs, such as California Kids and restricted Medi-Cal will cover urgent medical programs even for undocumented clients. A key question to keep in mind is, then, to what extent to members of farmworker households use these targeted programs? First a person who may qualify for a specific program needs

to find out more information. Just finding out information over the phone or in a county welfare office is a demanding, tedious, and somewhat humiliating process. Members of farmworker households do not utilize these programs since they may not know about them, and that is largely because they are promoted more extensively in urban areas.

Second, medical insurance coverage among farmworkers, although not ideal, is more than expected. Even so, farmworkers never seem to be able to take full advantage of various medical plans due to policy restrictions and changes in employment. And despite the geographic location and number of facilities, the number of public and private programs, and the moderate rate of medical insurance coverage, members of farmworker households still have a hard time obtaining affordable medical services when they need them the most. Although potential access to subsidized medical services is high, realization of access is low. The following section on realized access to medical services examines why these difficulties persist.

REALIZED ACCESS TO MEDICAL SERVICES

Realized health care access relates to the actual use of health care services to satisfy needs for health care services. Farmworker access to medical services in this study examines how current health policy regulations limit or facilitate access to medical care or both.

Health-Seeking Trends among Migrating and Non-Migrating Farmworkers

Overall, the vast majority of farmworker households (approximately 90 percent), both migrating and non-migrating, stated that they see a doctor when they are really sick. Even if a person does not have medical insurance, he or she will pay out-of-pocket for urgent problems. A prominent pattern seen among farmworkers and their dependents is

the tendency to delay treatment. When this happens, they tend to be sicker and the medical care needed is more costly when they finally seek care. More specifically, farmworkers are less likely to seek preventative care and seek care only when they are very sick. Their school-age children, however, are required to be up to date on their vaccinations. So, to some extent preventative medicine is practiced with children but not with adults.

Unless there is an obvious emergency, when members of farmworker households get sick, the tendency is towards self-treatment first with either traditional remedies or cosmopolitan medical practices or both. The next section elaborates on the two most common traditional remedies reported by farmworkers in this study.

Traditional Medical Practices

Approximately 60 percent of the 130 households sampled reported using herbal remedies for common ailments such as colds, stomach problems, insomnia, nervousness, and skin abrasions. Older farmworkers were more likely to report using these remedies than younger farmworker households, which were more likely to resort to over-the-counter remedies. The following interview reveals the knowledge of the herbal remedies most commonly used among Mexican-origin farmworkers.

> *Interviewer:* Now we are going to talk a little about the teas. Here are two women with me. I have 117 teas displayed on the wall and they are going to choose the ones they use and talk about each one. Please teach me, *Rosa de Castilla*?
>
> *Female Farmworker 1*: *Rosa de Castilla* is used as an infusion or tea. Put it in a small teapot and it can be used as a laxative for a small baby. *Arnica* is one of the marvels that nature has created. One can cook it and it is excellent, from my own

experience, as an antibiotic for a wound.

Interviewer: As an antibiotic, how?

Female Farmworker 1: Skin infections, wounds. Wash the wound three times a day with the boiled arnica water. It's better that whatever medicine a doctor will give you.

Interviewer: What else?

Female Farmworker 1: Sauco. The *Sauco* flower is a marvelous tea for coughs. You cook a mixture of one to two teaspoons *Sauco*, four *Eucalypts* leaves, and *Manzanilla*. Then you take this three times a day until the phlegm and cough diminishes. You can sweeten this infusion with honey.

Interviewer: We need to know how the people use these teas because we have to make sure that these traditions continue. Many of the young people, like me, do not know them.

Female Farmworker 1: Epazote is also a marvelous way to get rid of parasites. You can take it as a tea or you can also use it as a spice for food. For pozole, for chilaquiles, the spice gives a very agreeable flavor, but it is primarily used for the intestinal parasites.

Interviewer: For how many days?

Female Farmworker 1: Daily use won't harm you. It's good. *Manzanilla* is used for stomach pain and cough. You could even use it to color your hair. Cook *Manzanilla* and put it in your hair and you can become a blonde.

Interviewer: What else?

Female Farmworker 1: Ruda– another marvelous herb from Mexican herbal traditions. You can put the herb in a bottle of alcohol. When the alcohol and water mixture turns green, you can take a cotton ball, moisten it with the mixture, and use when your eye has sticky eye secretions (rheum). Sometimes the rheum isn't caused by infections but rather by a "golpe de aire" and you can clean the eye, making sure it doesn't go inside the eye, just around it. With the wet cotton ball you clean them, and it works wonderfully. You can also take it when you have a headache. *Ruda* with chocolate and an egg, if you take this it will help you sleep well. Sometimes girls like Kathy [referring to the researcher] that study and can't fall asleep– *Ruda* with chocolate and milk is enough to induce sleep and it removes your headache as well.

Interviewer: What else? (Laughing)

Female Farmworker 1: Cidron is also used as a tea for stomachache. You can use it daily, all the time like you were drinking coffee, but it is much safer. *Mejorana* is another. It is used for foods– caldillo, menudo, albondigas. It's for the kitchen. I don't use it as a medicine. *Albahacar* or *Basil* is for the stomach. It helps the stomach, but it is also used in the kitchen. You can use it for spaghetti. *Te de Limon* they say is good for nervousness. A small cup at night helps you sleep.

Female Farmworker 2: All these herbs that we have been talking about are very good. I have used them– it's through my own experience that I say this. One of the best ones is *Ruda*. Grab a little green leaf and you can make a compress and put it on your aching head or if you have "dolor de aire"– it is very good.

Interviewer: Do you know a tea for earaches?

Female Farmworker 2: Ruda also. You can put a cotton ball in your ear with small fresh Ruda leaves.

Interviewer: Are there teas for pregnant women?

Female Farmworker 2: Well this is something you will need to ask the people. *Manzanilla* they say is used when a women is about to give birth. You can take the *Manzanilla* when your pains begin, and all will be better. The tea can make the birth of the baby occur more rapidly.

January 1998 Spanish version in Appendix 2

Approximately five percent of the adults in this study reported using the services of a person commonly referred to as a sobador. A sobador typically massages sore muscles and, like a chiropractor, will realign the spine with certain movements. The following describes a female farmworker's experience with a sobador.

Female Farmworker: A sobador, a sobador, one should never do without. I think I will never stop seeing one. Every eight days I go see him. Don't want you to think that he will squeeze you too hard– no more than like this. He will hold your feet– like this making a cracking sound. He will look for your nerves and then crack the area. Sometimes when your knee hurts he will crack it– same with the forehead.

Interviewer: How is he called?

Female Farmworker: His name is XXX. It's a marvelous experience– you leave feeling good. Like me, my back sometimes hurts so much that it burns like Chile– it hurts so much, the only thing that I can do is see a sobador and he cracks my nerves here. But after he cracks my whole body, he does this with his hands and I hear crack, crack, crack– your head. He does it like this, no more. He also cracks

"las anginas" and then they never bother you again. What this man does is very interesting. I admire him, because before I had so many days that I was practically paralyzed– all those days especially in the beginning.

September 19, 1996 Spanish version in Appendix 2

Among the members of farmworker households whom I interviewed, traditional remedies do not take the place of seeking the services of an allopathic physician. Rather, traditional remedies are used for minor problems or when the farmworkers are displeased with the services of a physician. The uses of a sobador, for example, will sometimes be sought out after unsuccessful treatment from a physician. Moreover, some herbal remedies are used in conjunction with modern medical treatments. For example, if medications such as antibiotics give a person an upset stomach, Manzanilla and Peppermint teas will be used to soothe the nausea.

Medical Insurance Regulations and Realized Access to Medical Services

Realized health care access refers to the actual use of health care services to satisfy health care needs. Forces contributing to realized health care access can be as either facilitators or barriers. Examples of such variables include structural access barriers and facilitators that can be economic (price of treatment, childcare considerations, related costs of making time for clinic visits), geographic (transportation, location of clinics), or political (socio-political status). Possible cultural access barriers and facilitators, which affect use of services, include knowledge of available programs, mistrust of American health providers, and acceptability of medical services provided. Overall, this study focuses on the health policy structural constraints to potential and realized access to medical services for farmworkers both when they are migrating and when they are living

at homebase. Before beginning a discussion of the structural barriers characteristic of medical insurance policies, it is important to briefly examine all the different access barriers that farmworkers reported in this study.

When heads of household were asked whether their family members faced difficulties in obtaining medical services, the following were cited as reasons they were sometimes prevented from seeking medical services when they most needed to: too little money, no medical insurance, long wait, no medical specialists at the clinic, lack of transportation, little confidence with American physicians, language barrier, lack of knowledge of medical facility location, distant clinic location, lack of child care, failure to get permission to take time off from work, failure to qualify for MediCal, and lack of citizenship. Each one of these reasons is important to mention. However, the survey instrument used did not measure specifically which barriers most prevented potential and realized access to medical services. Moreover, situations change daily. For example, the lack of transportation may be a problem on one occasion whereas the lack of child-care may be a barrier the next time. Nevertheless, the most common difficulties cited were no money, no health insurance, problems with their health insurance, and the long wait characteristic of most doctor's visits. At this point it is important to examine whether or not members of farmworker household were denied access to medical services.

Denied Medical Attention

One important question asked of farmworkers was whether or not they were ever denied medical attention. More than 95 percent of heads of household reported that none of the members of their households had been denied medical attention. However, there were a few instances reported when medical care was delayed. The following interview passage illustrates this situation.

Interviewer: Have you or a member of your family ever been denied medical attention?

Female Farmworker: My son.

Interviewer: What happened?

Female Farmworker: He injured his hand and they didn't want to give him medical attention in Yuma. They were all ready to operate. The anesthetist was ready and everything. The doctor then asked if we had medical insurance and when I said that we didn't here but we had Medi-Cal [in California], he cancelled the operation.

Male Farmworker: They didn't want to operate.

Interviewer: Then what happened?

Male Farmworker: They couldn't operate that day, we had to wait some time, and when we had all the papers in order, they operated. But he had to wait almost a month.

Interviewer: What type of place denied you this medical assistance? A clinic?

Female Farmworker: No. A hospital in Yuma. Well, it wasn't really a hospital, but a doctor was there.

September 20, 1996 Spanish version in Appendix 2

Apparently, this family qualified for Medi-Caid. They even had Medi-Cal in California. But since they were back in their homebase area, they needed to reapply for the Medi-Caid program in Arizona. So even though this child ultimately received medical attention for his hand, the treatment was delayed a month. This was uncomfortable for the child and inconvenient for his parents.

Overall, there never was a reported instance when life-threatening medical treatment was denied. Rather, farmworkers in this study reported encountering barriers that resulted in the delay of treatment so that they could receive subsidized care. Most subsidized medical care services received by farmworkers in this study were in the form of Medicaid– Medi-Cal in California and Access in Arizona. Other types of subsidized care reported were free medical exams from Rota-Care staff and free dental exams at school.

Realized Access and Public Insurance

This section examines the complexities reported by farmworkers with various medical insurance policies. Analysis of the data indicates farmworkers and children with full Medi-Cal benefits used this medical insurance and were the most pleased with their coverage of all people in the study. Those on managed-care Medi-Cal complained about provider restrictions, and those with restricted Medi-Cal benefits were not pleased with the limitations, and there was confusion over what was covered and what was not. However, even when a farmworker applies for these programs, the eligibility process is tedious, confusing, and redundant. Moreover, clients need to be re-certified at least quarterly– every 45 days in most counties. Problems using Medi-Cal were also created when a client also had a marginal employee-based medical insurance plan. The next interview passages describe the cycle of having marginal employee-based insurance while working and then applying for Medi-Cal when unemployed.

Interviewer: Is there a time in your life when you don't have insurance?

Female Farmworker: Yes, when I am not working, I have no insurance.

Interviewer: And what happens?

Female Farmworker: I apply for Medi-Cal.

Interviewer: Is it easy for you to receive Medi-Cal?

Female Farmworker: It is a little difficult since we come from Yuma [Arizona]. We have to send papers every month, every month. One month they will give it to us, and another month no. Right now I have a problem, my husband needs medical attention because he is sick, but they denied us Medi-Cal this month. They denied me once because the company provides us with medical insurance, but this insurance doesn't cover everything. Then I applied again because my husband needs to be attended to, but they denied my husband and I. Only my children qualify for Medi-Cal. My husband has an illness that is called an ulcer and it needs to be checked every month, every two months. The company gives us insurance but it doesn't cover everything. The insurance only covers 80 percent, that's all it covers. And he [her husband] has an appointment for the 26 of September. In this appointment they are going to take a camera and look inside. I explained this to the social worker, but despite this, they are not going to give me Medi-Cal. I wanted to see if they would give me Medi-Cal because the insurance doesn't cover all that Medi-Cal does, but they denied me Medi-Cal. And he is a citizen, here he works, here he lives, but they still deny him Medi-Cal.

September 19, 1996 Spanish version in Appendix 2

The passage above reveals not only the transition between employee-based medical insurance and Medi-Cal but also the frustration felt by farmworkers because the private insurance plans do not adequately cover medical costs. The next interview passage reveals the uncertainties that farmworkers face as they are moved into managed

Medi-Cal plans.

Interviewer: Do you have Medi-Cal or not? … What are you going to do?

Female Farmworker: The problem that I see is that they are going to change our regular Medi-Cal, and we want it to remain the way it is.

Interviewer: You say that your Medi-Cal plan is going to change?

Female Farmworker: Yes.

Interviewer: Why?

Female Farmworker: They have told us that Medi-Cal is not going to be like the plan we already have. That now mine will be called ProCare and another name. But we want ours because one time I tried ProCare and I don't like it because it doesn't cover the same doctors, medicines, like it did before.

Interviewer: Then this is an HMO? …

Female Farmworker: Yes, we have to change to this other type of Medi-Cal like I said; this one doesn't cover our doctors like it should.

Interviewer: Is this new Medi-Cal going to cover services in this valley, or do you have to go all the way to Riverside or other places?

Female Farmworker: What they told us is that they are going to send us a package, and that they are going to put the doctors that they want. But we want our doctors. Apparently, they only want us to choose one doctor. But if I choose the doctor that is here in Mecca, and the clinic is closed, what are we going to do if we need to go see another doctor because the clinic is closed? It would be better if we could choose two doctors but they say no more than one.

March 1997 Spanish version in Appendix 2

This passage demonstrates the potential problems that farmworkers have with managed care in an isolated rural area where there are few doctors. The following passage illustrates other problems that members of farmworker households have with Medi-Cal.

Interviewer: This woman does not have medical insurance right now, and she is going to explain the process she goes through to get medical insurance.

Female Farmworker: First, I have to work a month before I can qualify. But we have already gone to Mexicali, because here we have to first pay $100 and then they will cover me.

Interviewer: Will this insurance cover your children?

Female Farmworker: Yes.

Interviewer: Since you are low income, don't you qualify for Medi-Cal?

Female Farmworker: Yes we are low income, but there is this new law that is about to take effect.

Interviewer: But you have your permanent resident care, what about Medi-Cal?

Female Farmworker: Well, I don't know, they just said no.

Interviewer: And they said because there was this new law?

Female Farmworker: That there was this new law.

Interviewer: That said what?

Female Farmworker: That one has to qualify for this. Well, I don't really understand this very much because I was filling out so many forms, and they also asked for the company where my husband works. I went three times to the social worker and, well, she said that the forms weren't filled in properly. So I returned

to fill them out, I returned again to fill them out. And after all that, they said that we didn't qualify. I have not gone back to try to fill them out again because since I do not drive, I have to ask for a ride.

Interviewer: This is important that you say this.

Female Farmworker: My little girl of four years, she was getting sick with this infection in her throat that later traveled to her ear, and pus came out and she had a fever.

Interviewer: Yes.

Female Farmworker: She was getting really bad, and I was talking to my social worker, and she said that I should take her to the emergency room! But she also said that I was not covered. So what would have happened if I took her to the emergency room and I had to pay all that they were going to charge me at the hospital?

Interviewer: So what happened, did you take her to Mexico?

Female Farmworker: Well somebody was going to Mexicali and I went with them. In Mexico they gave me the medicine and it was cheaper.

March 22, 1997

We can learn a lot from the passage above. First, this woman was frustrated that she would have to pay a $100 deductible before she would be covered by her husband's medical insurance. Then she alludes to the new law. In 1997, there was confusion in California among social workers– apparently this social worker went by the federal guidelines that stated that permanent residents arriving after August 22, 1996, could not receive Medicaid benefits. However, having spoken with Medi-Cal supervisors in

Riverside County, I also knew that they were not going to enforce it since there was state legislation pending that would restore some of the Medi-Cal benefits to immigrants. It appears that members of this farmworker household were, thus, denied benefits, even though they may have been qualified. This women also points out that she had to return to the social worker's office several times because the forms were not filled out correctly. By law, social workers are not supposed to fill out Medi-Cal applications. However, since these applications are so long and tedious, many social workers "help" farmworkers to fill out these applications. This probably explains why she returned to the office so many times. She was looking for someone to assist her. But as we can see, she finally gave up, and when her child was sick, she got a ride and treated the child in Mexico. However, it must be pointed out that some farmworkers have visas that do not permit them to go back and forth between Mexico and the United States. Others are undocumented or in the process of getting legal authorization to work in the United States. Just going to Mexico for medical services is not an option for all farmworkers. The next interview describes the difficulties associated with having two medical insurances at the same time.

> *Female Farmworker*: Yes, they operated on the tonsils of my little girl in Mexico because the insurance covers 100 percent over there and only 80 percent here. Over there I don't have to pay anything, even though I have Medi-Cal. Well, to be involved with two insurances at the same time is a bit complicated because they keep sending me bills, and bills, and bills and this makes it difficult to pay someone. And I can't pay the other one because the two of them are making it difficult.

Interviewer: Do you then prefer to only have Medi-Cal or only have Transwestern?

Female Farmworker: I prefer, if I could, to have Medi-Cal because when I have Transwestern, and I stop working, then they terminate my insurance and I have nothing.

Interviewer: Over the course of a year, are there times or months in the year when you only have Medi-Cal?

Female Farmworker: Yes, there are months when I only have Medi-Cal.

Interviewer: What months? In the winter?

Female Farmworker: No, it is when the season ends for us in the packinghouse– June, August, and September.

Interviewer: Then your child needed to have the operation in which month? Last month?

Female Farmworker: She had the operation in March or April.

Interviewer: Okay. Yeah.

Female Farmworker: As for me, they operated on my nose.

Interviewer: Another operation? In Mexico?

Female Farmworker: In Mexico– because I had a deviated septum.

Interviewer: What?

Female Farmworker: A deviated septum. I don't know what they call it... I had a deviated septum, and I had the same problem (with insurance) and I went in May.

Interviewer: Then you didn't want to use Medi-Cal and Transwestern because of the difficulties?

Female Farmworker: No, if I used them both it would be more difficult. Because when I used them both, both would send me bills, these bills would keep arriving and arriving. But when I used the insurance [Transwestern] in Mexico, everything was covered, they just sent one paper about what the insurance covered and that was it.

April 7, 1997 Spanish version in Appendix 2

According to the provisions of Medi-Cal, a person can have insurance through work and still qualify. However, if you let it be known that you have two medical insurances, each one will try to get the other to pay more of the medical bill. As this farmworker learned, she used her employee-based medical insurance in Mexico only so she could have everything covered. If she were to use Transwestern in the United States, it would only cover 80 percent of the costs, and they would probably try to get Medi-Cal to pay for some of the expenses. This farmworker household, however, does receive Medi-Cal benefits during the summer when she is not working. This passage also demonstrates that her employee-based medical insurance only covers her household while she is working. Nevertheless, this farmworker household is fortunate. She is part of the 40 percent of the farmworkers in this sample who receive employee-based private medical insurance. On the other hand, approximately 60 percent of the adults in this sample do not receive employer-based private medical insurance. In addition, typically most farmworkers lose their Medi-Cal coverage when employment causes their income to rise. Therefore, many members of farmworker households have no medical insurance coverage when their occupational risk is at its highest.

Members of farmworker households who have complete Medi-Cal coverage with a zero or a minimal share-of-cost can readily find primary health care services in the Coachella Valley as long as they receive care in the same county where they applied for coverage. But Medi-Cal coverage is not continuous for farmworker households. Moreover, clients need to be re-certified at least quarterly-- every 45 days in most counties. This can be problematic since the forms are difficult, and migrating households typically do not have their mail forwarded to their upstream residence. The next section elaborates on the intricacies associated with private employee-based medical insurance.

Realized Access and Employee-Based Medical Insurance

Farmworkers may have the option of some type of employee-based private medical insurance. As with most occupations, a farmworker has to work in a given job for certain period of time to qualify. The following interview passage illustrates this.

> *Interviewer:* You mentioned something about having to work a certain number of hours before you can use your medical insurance. Please explain to me this process.
>
> *Female Farmworker*: We have to work a certain number of hours, I am not sure how many they are, but we have to work these hours before qualifying for this insurance.
>
> *Interviewer:* Then do you qualify for this insurance this month?
>
> *Female Farmworker*: For this month, no, and we are going to finish our work anyways. Because the work is over and stopped, I have to begin again, and I have to work these hours again in order to have the insurance.

Interviewer: After all this, are you going to ask for Medi-Cal for you and your children?

Female Farmworker: I more or less always have Medi-Cal. Right now, though, they have taken it away and I do not know why. I have problems with my social worker– she doesn't send me the reports and so they haven't been filled out, and they probably took me off Medi-Cal.

February 24, 1997 Spanish version in Appendix 2

The farmworker profiled above reports having trouble with both types of medical insurance. The paperwork and the different rules for the different companies are confusing. It is important to point out that even though this farmworker is a non-migrating farmworker, she also had trouble receiving continuous employee-based medical insurance. In the Coachella Valley, there may be work available year round, but few farmworkers interviewed in this study had continuous employment. For example, in the Mecca area, there are several grape fields owned by different companies. If one is a field laborer, then it is very likely that they will work for all three companies in a short period of time, thus never getting employee-based medical insurance while simultaneously being disqualified from Medi-Cal because of their rise in income. Some farmworkers interviewed had decent coverage. For example, the farmworker profiled below is a crew leader who migrates for the same lettuce company year round.

Interviewer: What is the name of your medical insurance?

Male Farmworker: Western, hm, I not sure, I don't want to tell you lies. For crew leaders like us, they cover up to $5000, 100 percent. Like recently, my wife when she had the twins, she had many problems. I think that it reached more that

$100,000 and I did not have pay a nickel– I paid nothing. And the field laborers– if, for example, I had to take my child, I would have to pay a $500 deductible. If I were a field laborer I would have to pay the first $500 for the child's illness, but if it was something minor, it would cost $30 if I had not reached $500 for the year. But if they were to go over $5000 [pause] but for me they pay 100 percent. For the field laborers, they pay 80 percent after paying the $500 deductible for a family or $200 for a single man or woman. If you are a single man or single woman then you have to pay $200 of your deductible and then they [the insurance] begins to pay 80 percent of the costs.

September 13, 1996 Spanish version in Appendix 2

This interview passage illustrates several interesting points. First, crew leaders and other people working in jobs higher up in the agricultural hierarchy receive better medical insurance than average farmworkers. He does not have to pay a deductible, and it does not seem that he had a cap on his coverage. When examining these passages he mentions $5000 twice without completing the sentence. I later learned from other field workers that not only do field workers have a deductible to meet but they also usually have a $5000 per year cap on coverage. The next interview passage further explains the nuances of employee-based medical insurance for farmworkers. In this case, the farmworker decided to obtain only dental insurance.

Interviewer: When was the last time that you or your daughters had dental treatment?

Female Farmworker: I bought insurance, well I really didn't buy it, my work offered me this insurance but they are taking deductions from my check. That is

why I said I bought this insurance because they are not giving it to me. Every two weeks they take 25 dollars from my check for this dental insurance.

Interviewer: Do you know what the name of your insurance is?

Female Farmworker: I don't know, but here I have my card.

Interviewer: The insurance doesn't cover anything medical, only for the care of the teeth?

Female Farmworker: I believe only that– that is all that they do. But when she had a cavity, they drilled the holes but they didn't fill it in, and she got an infection.

Interviewer: Then at work they only offered you dental insurance and not health insurance?

Female Farmworker: No, well, they offered me health insurance, but I had to buy it, and having both of them would be too much, almost double.

Interviewer: For that reason you only have insurance for your teeth?

Female Farmworker: Well, the dental insurance was cheaper and the health insurance cost so much more.

Interviewer: You said that they didn't fill in the cavity?

Female Farmworker: No they drilled a hole and my daughter said, 'They left me with a hole, and they didn't fill it in!" But she didn't realize it until we were already returned to Arizona.

September 19, 1996 Spanish in Appendix 2.

The passage above clarifies employee-based medical insurance even further. This farmworker was aware of what she was offered and decided to opt only for the dental plan because health insurance was too expensive. This is interesting. Sixty percent of the adults interviewed stated that they did not have any form of employee-based medical insurance. And like many researchers I assumed that this was because their employer did not offer it to them. However, it is possible that some farmworkers chose not to have insurance deductions from their check. Future research needs to make this distinction.

As illustrated by the farmworkers' experiences in the interview passages above, it becomes apparent that employee-based medical insurance has many limitations and disqualifies some farmworkers from the more comprehensive Medi-Cal coverage and other types of subsidized care. For example, sometimes farmworkers deny that they have private coverage when they go to the Mecca Clinic because they haven't met their private-insurance deductible. This is problematic since the clinic loses money when it offers a patient a sliding fee scale. Moreover, coverage under private insurance offered by the growers usually does not take effect for several weeks. For farmworkers, there is a constant flux of changing medical coverage from no coverage to private coverage to public coverage, depending on county residence, income level, and type of employment. Migrating and non-migrating farmworkers often work for multiple employers with different health policies over the course of a year. This puts them at a disadvantage for medical insurance coverage.

Thus, marginal, limited, private medical insurance coverage can often be detrimental for the low-income farmworkers since this can lead to more out of pocket expenses and may be disqualify them from public insurance programs. Many

farmworkers with modest private insurance end up paying completely out-of-pocket for their medical services, often because they never meet the deductible within the time period required. As one farmworker said, "It's like having no coverage at all." Some of the policies reported by farmworker households in this study include the following: Blue Cross, Golden Ace Farms Group, Great West Health Plan, Health Net, Health Net Select, Metra Life, Pan Pacific Benefit & Administration, Pru Care HMO, PTA Arizona, Robert F. Kennedy Farmworkers Medical Plan, SMA Healthcare, Transwestern, United Agriculture, and Western Growers.

Realized Access and Services in Mexico

One of the more interesting findings in this study was that insurance companies based in the United States were offering farmworkers full coverage if they received medical services in Mexico and 80 percent coverage if they obtained medical attention in the United States. This benefit was appreciated by farmworkers interviewed in this study. However, it is not an answer for all farmworkers. For example, for farmworkers working in Northern California, the distance needed to travel to Mexico is often costly and not feasible. Moreover, some farmworkers with certain types of immigration status cannot enter Mexico and then re-enter the United States. Another interesting finding is that the Mexican government is willing to subsidize a medical insurance program for Mexican Nationals, Mexican Americans, and their family members. Although only one farmworker household took advantage of this pre-paid Mexican health plan, it may gain popularity in the future. More commonly, farmworkers often obtained prescription medicines bought in Mexico for their use while living in the United States.

As pointed out earlier, approximately 30 percent of the members of farmworker households reported having no medical insurance at the time of the interview. Usually this lack of medical insurance was actually a gap in medical insurance coverage.

Realized Access and the Uninsured

The following interview passage examines what can happen to an uninsured farmworker.

Interviewer: Has anything ever occurred to you because of a lack of medical insurance? You mentioned to me that you had some problems with Medi-Cal and your teeth.

Female Farmworker: I lost two molar teeth because they cancelled my Medi-Cal insurance. I was not working and I did not have proof of income. My little girl also really needed to see a dentist. My two teeth were also very bad and I did not have the money or the insurance, so I lost the two molars, the two teeth. My six-year-old daughter's teeth also suffered a great deal.

Interviewer: Did you like Medi-Cal when you had it?

Female Farmworker: Yes, but when I had it, they cancelled it two times when I left work and my husband was disabled. We weren't receiving money and they cancelled it when we most needed it. Because I didn't have proof of income– they ask for paychecks.

Interviewer: Why didn't you go and get unemployment?

Female Farmworker: Because I do not qualify for unemployment. In this district you can't get unemployment. Even when you take your paycheck in, they don't accept it. I had no money. I had no work.

Interviewer: Where you able to actually go to the unemployment office.

Female Farmworker: They ask for proof of income from work, pay checks. I brought the paychecks, but they wouldn't accept them because it was only temporary work. And when I was applying for Medi-Cal, I brought the paychecks from three different companies where I had worked. I worried a lot. I also needed to go to the doctor because I had pains in my ovaries, but I couldn't go to the doctor. Now that they have given me Medi-Cal, they are going to do a sonogram and see what it is that I have.

February 18, 1998 Spanish version in Appendix 2

This passage illustrates that during a gap in her Medi-Cal coverage, she lost two of her teeth. Like many female farmworkers, she works in a series of several agricultural jobs for different companies. As a non-migrating farmworker, she was eventually able to get Medi-Cal coverage because she was persistent and able to travel to the Medi-Cal office several times.

As we have seen, the regulations of the various types of medical insurance programs do impact farmworkers' use of medical services. The next section examines realized access to medical services for both migrating and non-migrating farmworker households.

Examining Realized Access

In a given agricultural season, many California resident farmworkers migrate for a period of time outside their county of residence. This unique labor condition of traveling from county to county, and even between states, poses special problems in terms of access to medical services. In California, if a farmworker household on some type of

public assistance program migrates to another county, he or she may become ineligible for public services if the case is not transferred in a timely fashion. Access to care for most farmworkers who qualify for public programs is in practice limited to the geographic county in which they applied for coverage. Taking advantage of public medical insurance is difficult during migration because of the county residency requirements for Medi-Cal. Moreover, farmworkers often find the use of private insurance problematic when they are migrating, because of the confusion over qualified providers. The requirement to meet a medical insurance deductible is difficult not only because of cost but also because it is harder to prove how much of the deductible has been paid in the homebase location. If a member of a farmworker family seeks care in a clinic while migrating and the medical insurance company office is closed, he or she may be asked to pay the deductible again.

For those private insurance programs that offer coverage for care and treatment in Mexico, distance to the border may become an access issue during migration.

Most non-migrant farmworkers interviewed in this study do not face the same structural barriers to medical services as migrating farmworker households. In this sample, non-migrating farmworkers who live in the desert Southwest are also better able to utilize medical services in Mexico since those services are only an hour's drive south. But non-migrating farmworker households do experience financial difficulties in meeting high medical insurance deductibles. Single parent households have the most difficult time paying for the co-pays and deductibles characteristic of most private medical plans.

Some non-migrating farmworkers perceive that migrant farmworkers receive better services. Some farmworker women pointed out that some households migrate for

the minimum amount of time allowed in order to qualify for the subsidized day-care programs in Mecca. There is a tension arising between migrating and non-migrating farmworker households because of scarcity of resources.

Finally, my research uncovered one group of non-migrating farmworkers with unique health concerns, though it is not included in the statistical sample. Currently, hundreds of mostly undocumented non-migrating farmworkers rent out Native American land in isolated areas near the Salton Sea. These areas are among the poorest in rural California, with enormous public health concerns and implications, poor sewage, contaminated water, open pools of water festering with insects, improper garbage and sewage disposal, wild dogs, incorrect electrical connections, no drainage for water run off, and improperly installed propane tanks. Farmworkers in these areas live in the poorest trailer encampments and largely remained hidden from public view. The Immigration and Naturalization Service is much less likely to enter these lands unannounced, and housing regulations for mobile homes and trailers are less restrictive. Unless married to a Native American, most are not eligible to use the nearby Indian Health Services facilities. This group of farmworkers, largely due to their undocumented status, is probably one of the most marginalized groups of rural poor living and working in California.

The data from this research indicate that members of both migrating and non-migrating farmworker households experience significant challenges that affect their well-being. Neither group should be excluded from consideration for farmworker benefits.

SUMMARY

There are important distinctions between potential and realized health care access for both migrating and non-migrating farmworker households. Alan Dever, a researcher from the Mercer School of Medicine, finds that farmworkers residing in "upstream" non-homebase areas can access medical services more so than farmworkers living and working in homebase areas. In addition, Dever explicitly argues that, "Access to health care services tends to be more limited in migrant homebase areas than in non-homebase areas due to the concentration in homebase areas, than in non-homebase areas, of other potential clinic users who compete with farmworkers for access to services" (Dever 1993).

This dissertation research reports more complex findings. Non-migrating farmworkers are not necessarily better off, especially if they do not have stable work. Migrating farmworkers, even those living under decent housing situations, still face more structural barriers when they use private and public medical insurances. When using Medicaid, for example, it remains more difficult for migrants to have their cases transferred, to keep up with the paperwork required for re-certification, and to understand the changing eligibility requirements between counties. When using private medical insurance, it is more difficult for migrants to know which health providers are covered by their plan, to prove how much of the deductible they have paid and to travel to Mexico for full coverage.

Potential and realized health care access depends on a number of variables. In California, the most significant factors impacting both potential and realized health care

access are type of medical insurance coverage, the stability of the work, and the possibility that a person can seek medical services in Mexico.

It is important to point out that, overall, in only a small percentage of households are all members covered by medical insurance. In some cases, the documented father and the American born children have health insurance while the undocumented mother does not. In other cases, the parents have no insurance, but resident children and those with citizenship qualify for MediCal while the undocumented kids in the family have no coverage. Moreover, some of the families who have private health insurance do not use it because of high deductibles and fear of retribution from their employer. Cases like these exemplify a high level of potential health care access and a low level of realized health care access.

Therefore, it is important to emphasize that marginal private insurance coverage and restricted public medical insurance coverage may not increase levels of realized access. Such circumstances translate into more out-of-pocket expenses for the farmworker and thus farmworkers may delay care.

This discussion of farmworker access to medical services focuses on how health policy regulations both limit and facilitate access to medical care. This research argues that structural access barriers inherent in public and private health insurance programs for farmworkers severely limit access to medical services. Thus, having health insurance in it and of itself does not mean access to health services. Access exists when one is able to use the potential services offered. The following chapter discusses these findings from the theoretical perspective of political economy of health.

CHAPTER 7: THE POLITICAL ECONOMY OF HEALTH CARE ACCESS

Following the perspective of a political economy of health as articulated in medical anthropological theory, this research examines how structural policies inherent in medical insurance programs affect access to medical services among farmworkers. Theoretically, this research strives to uncover how structural policies implemented locally are influenced by national and international macro-level political and economic forces. First it is important to briefly demonstrate how medical anthropological theory came to include the political economy of health perspective.

Critical Medical Anthropological Theory

Critical medical anthropology can be described as a subspecialty of the sub-field of medical anthropology. It differs from earlier medical anthropological frameworks in its attempt to integrate theory, practice, and advocacy. Critical medical anthropology began as a response to earlier medical anthropology theory that did not address the macro-level and social relations and that emphasized ecological reductionism (Singer 1989). This earlier medical-ecological emphasis in medical anthropology, sometimes referred to as the biocultural approach, often assumed that the health status of a given population was a measure of how well this given population had adapted to its physical environment (Singer and Baer 1995). The biocultural approach, however, has been criticized for not focusing on the stresses created by unequal social relations. Merrill Singer outlined and defined critical medical anthropology as a

> theoretical and practical effort to understand and respond to issues and problems and health, illness, and treatment in terms of the interaction between the macro-level of political economy, the national level of political and class structure, the

> institutional level of the health care system, the community level of popular and folk beliefs and actions, and the micro-level of illness experience, behavior, meaning, human physiology, and environmental factors (Singer 1995).

This very inclusive definition of critical medical anthropology leaves room for the critical medical anthropologist to analyze health, sickness, disease, and human affliction from a political economic, post-structuralist, or even a biocultural perspective as long as an examination of social relations is embedded in the analysis. It is important to point out, for example, that some medical anthropologists utilizing the biocultural emphasis are now incorporating an examination of social relations into their critical analysis. Most notably, Carey, in his biocultural study of morbidity in the rural Peruvian Andes, asserts that

> In addition to understanding the biological health consequences of local social relations and the efficacy of individual adaptive coping responses, the model should more thoroughly examine how broader macrolevel social forces affect the local system by shaping social structure and/or access patterns to critical material and social resources... (Carey 1990).

Additional confusion has occurred because the label "critical medical anthropology" has mistakenly been used synonymously with the perspective of the political economy of health (Morsy 1990). However, as Merrill Singer points out, critical medical anthropology is much broader in scope (Singer 1990) and consequently the political economy of health perspective represents only one of the frameworks that critical anthropologists utilize. The following section elaborates on the political economy of health perspective characteristic of critical medical anthropology theory.

Political Economy of Health

The political economy of health framework in critical medical anthropology owes its development to the merging of many intellectual traditions, most notably postmodernism, cultural critiques of medicine, and theories of global inequality (modernization, dependency, and world systems). These intellectual traditions that contribute to the political economy of health framework articulate a frustration with the social injustice exhibited in society. Their contributions to critical medical anthropology are found in their differing explanations of the social processes involved in obtaining material and social resources in society.

The theoretical underpinnings of this research asserts that the political economy of health perspective, as currently articulated by critical medical anthropology, has the potential to clarify some of the structural processes that influence access to medical services among farmworkers. Initially the political economy of health perspective in critical medical anthropology received much attention. This heavy emphasis on political economy and macrolevels of analysis, however, drew criticism in that, "Even those sympathetic to a critical stance jumped to the conclusion that critical medical anthropology focuses on things and not people, the macro and not the micro, abstract systems and not concrete feelings and experience, behavior and not meaning, structure and not agency" (Scheper-Hughes and Lock 1986 as cited in Singer 1990, and Scheper-Hughes 1986).

According to Chavez, political economy in medical anthropology "has been influenced by three major concepts: the social origins of illness, the allocation of health resources, and underdevelopment" (Chavez 1986). Moreover, Leatherman et al. points

out that political economy from the perspective of critical medical anthropology "highlights historical precedence, external political-economic relationships and their impact not only on the structure of local social relations, but also on how individual actors use their resources and environment" (Leatherman et al. 1993). Some have criticized this approach, however, as not well suited for applied research because of its close attention to macrolevel systems, its inability to demonstrate the links between micro-macro forces, and because of its advocacy tone (Singer 1993, Baer 1993). Despite the shortcomings of this perspective, I maintain that the political economy of health perspective articulated by critical medical anthropology provides an important foundation for the analysis of access to medical services in a rural agricultural community.

Critical medical anthropologists who define what is meant by a political economy of health perspective distinguish this analytic approach from that of other researchers who include political and economic factors in their analysis of health care policy. Morgan argues that the political economy of health theoretical perspective in should contextualize history, conflict models of social change, and includes a multi-factorial theory of disease causation that incorporates social etiology (Morgan, 1987: 132). More specifically, Morgan defines political economy of health as a "macroanalytic, critical, and historical perspective for analyzing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political and economic relations within the world economic system" (Morgan 1987:132). Through her work, Morgan essentially redefined the political economy of health theoretical framework by critiquing earlier studies that used dependency theory as the focal point of political economic analysis. Morgan argues that these works examined

health and disease by relying too heavily upon a spectrum of dependency theories which de-emphasized structural inequities by focusing on capitalist markets and economic relations as opposed to social relations (Morgan 1987).

Critical medical anthropology, using the framework of the political economy of health, strives to consider how macro-level political and economic structures and processes dominate the understanding of health care programs by linking these forces with micro-level analysis (Baer 1993). This micro-macro linkage is made by means of examining the interactions between the micro-level of individual experience in illness, behavior, physiology, and environment with the macro-level of world political economy, national level political and class structures, and health care institutions (Singer 1995). This macro-micro linkage is done with the purpose of explaining actions and beliefs at the community level. The challenge in this study of health care access among California farmworkers is to help explain the linkage of macro-level social forces to health-seeking behaviors empirically observed at the local level.

Political Economy of Health and Farmworker Access to Medical Services

This research project incorporates farmworkers' own accounts to understand constraints apparent in health care programs that target California farmworkers as well as other rural residents. Specific policy constraints inherent in various health care programs for low-income California residents become apparent when we examine the self-reported health-seeking stories among those interviewed. Systematic data collected on farmworker experiences with medical services uncovered macro-level health insurance policies that limit both potential and realized health care access.

This research argues that structural access variables inherent in public and private health insurance programs for farmworkers severely limit access to medical services. These forces, which are embedded in socio-cultural processes, explain who accesses medical services, why they do so, what type of care they receive, how they access it, and where they go for these services.

Global Structure of Agricultural Labor

One very important influence on access to medical services among farmworkers is the global structure of agricultural labor in the United States and abroad. There are a large number of recent immigrants eager to work in this industry. This situation contributes to a system of labor that puts the employer at an advantage. Griffith and Kissam emphasize that large systemic forces constantly contribute to changes in the composition of the farmworker labor force in the United States. For example, in their comprehensive study on labor conditions of farmworkers working in the United States, Griffith and Kissam asserted that their study reveals,

> that the central California labor market is affected not so much by "surface level" changes in the social and economic framework as by more slowly acting, deep level forces– the evolution of migration networks; the changing face of what is now a hemispheric, if not global, agricultural economy; long-term demographic and social changes in American culture and the immigrant population; and the development of the local economy and infrastructure ... (Griffith and Kissam 1995).

These global economic forces contributing to the structure of agricultural labor in the United States are not the focus of this study. However, the macro-level forces that give

shape to this labor system do influence whether or not employer-based medical insurance is offered at affordable rates to individual workers. In this study, only a minority of companies offered affordable and meaningful medical insurance coverage to their employees. Though medical insurance coverage does not guarantee realized access to medical services, it does increase the potential for a member of a farmworker household to use medical services covered by these plans.

In order to link macrolevel health policies to health-seeking access behaviors empirically observed at the local level, it is important to discuss political forces at the national and state levels that affect use or non-use of medical services among farmworkers. Results in the previous chapters indicate that legislation at the federal level, and health policy decisions made at the state level are structural decisions that impact the ability of farmworkers and their dependents to use medical services in California. The following sections examine how community and migrant health centers and recent immigrants are affected by these structural decisions.

Federal and State Policies Impacting Community and Migrant Health Centers

This research reveals that many levels of federal and state health care policy decisions determine how Community and Migrant Health Centers throughout California operate. Staffing bi-lingual and bi-cultural medical practitioners continues to be a critical need in communities serving farmworkers. For example, foreign-trained medical doctors on J1 visas and National Health Service Corp physicians are often assigned to these federally funded clinics. However, they typically do not stay in these rural communities after the end of their initial contract. There are many reasons for this. However, what is missing for many medical providers working in these isolated rural clinics are

professional links with the medical community. This research reveals critically weak or non-existent communication between the largely state-funded University of California Medical Centers and the federally funded Community and Migrant Health Centers in most rural areas of California with the exception of the Fresno area. Moreover, although federal and state money supports the training of physicians, the distribution of these training programs is concentrated in urban areas.

Inadequate management of medical record data burdens Community and Migrant Health Centers in rural areas. Data are forever entered but seldom can be extracted for meaningful analysis. Medical schools, public health schools, schools of social science, and schools of computer science need to come together to discuss the effective automation of medical records for Community and Migrant Health Centers. This is an increasingly salient issue, since many of these clinics are signing with managed care providers that require detailed productivity reports.

Finally, one of the most difficult issues facing the Mecca Health Clinic, as well as other Community and Migrant Health Centers, concerns the medical treatment for both legal resident and undocumented immigrant clients who have little money. These clients are usually able to receive subsidized emergency health care services. But due to recent legislation regarding new immigrants, some of these federally-funded community clinics will have to find more ways to absorb the cost associated with uncompensated care. The following section elaborates on this issue.

Federal and State Legislation Impacting Immigrants

Because the newly enacted Welfare Reform Bill gives states the option to restrict Medicaid for legal immigrants, many farmworker families, who are legal residents but

not citizens, face restrictions (Washington Newsline 1996; Medicare and Medicaid Guide 1996; Rosenbaum 1996; Super 1996). According to the federal regulations, those who can prove that they have worked here for 10 years can apply for these benefits. Across the nation, in the next five years there will be fewer and fewer new immigrants who qualify for these services. This will result in an additional loss of income for many Community and Migrant Health Centers throughout the United States. In California, recent legislation is attempting to circumvent these federal policies by infusing state-only funding into publicly subsidized programs for recent and undocumented immigrants. Nevertheless, at the local level farmworkers and their advocates are concerned about the sustainability of these new state allocations of resources.

Moreover, it is important to point out that other recent changes in California reflect an anti-immigrant stance. For example, the passing of Proposition 187 by voters on November 4, 1994, which made undocumented persons ineligible for public social services, public health care, and public school education, created a great deal of confusion among farmworkers about who qualified for what services. Other state laws have ended affirmative action and have restructured bi-lingual education that affected the children of farmworkers. These various legislative actions at the state level have created anxiety among the farmworkers interviewed for this study. There is a perception that it is risky to use public services, especially since many of the laws cited have consequences that affect the immigration application process. For example, this research has already come across several families who are sponsored immigrants. Many are in need of health insurance, but they will not apply for any type of public benefit because they fear losing their visas. It is not clear what will happen to these families if they are low-income and in

need of continuous subsidized primary health care. Although there have been recent attempts to clarify public charge legislation, the guidelines are still not clear. However, it is clear that federally allocated Medicaid dollars cannot be spent on most recent immigrants who have come to the United States after August 22, 1996. Confusion about these laws leads farmworkers to seek medical services in Mexico or to delay treatment for non-life threatening conditions or both.

Structural Medical Insurance Barriers at the Local Level

In this population, only a small percentage of families with medical insurance have insurance for the whole family. For farmworkers with private insurance, dependent coverage may be limited. For farmworkers covered by public programs, family members who are undocumented are eligible only for Restrictive Medi-Cal. Most farmworkers will seek treatment when they are very sick, regardless of coverage. However, farmworkers delay seeking treatment because of inability to pay either because they have no insurance or they have not met their deductible.

Among those farmworkers interviewed who are eligible for public health insurance in the form of Medicaid, actual use is restricted by lack of awareness of how these programs work and by the difficult and confusing application process and eligibility procedures. Use of public coverage is also restricted by difficulties in transferring caseloads and eligibility information from one county to another when households migrate for agricultural work. Potential and realized access to care for non-life threatening emergencies and for tertiary/specialized care can be restricted by each county's interpretation of its legal responsibilities to persons covered by Medically Indigent Adults Program and/or Restricted Medi-Cal. In addition, quarterly re-

certification under the Medically Indigent Adults Program and Medi-Cal programs remains a major obstacle to actual use of these programs by eligible farmworkers and their dependents.

Although there is a wide range of private insurance programs available to some members of farmworker households, high deductibles, caps on coverage, and limitations on dependent coverage restrict the use of these programs. The time needed to travel in order to obtain care from permitted medical providers also restricts farmworker access use of private insurance.

Given all these barriers, it is interesting to examine whether or not farmworkers would be interested in paying for an independent source of medical insurance. Statistical data from this research project reveal that most farmworkers are willing and able to pay for an affordable monthly medical insurance. More specifically, 88 percent (n=98) of the farmworkers asked, revealed that they were willing to pay for a monthly pre-paid health insurance plan that didn't ask about documentation status. This willingness to pay was equally distributed between migrating and non-migrating farmworker households. The average amount farmworkers indicated that they were willing to pay for monthly pre-paid health insurance was $35.00. The average amount that farmworkers were willing to pay for a consultation with a general practitioner was $19.00. The average amount that farmworkers were willing to pay for a specialist was $36.25 and the average amount that farmworkers were willing to pay for an emergency visit was $53.00. Finally, the average amount that farmworkers were willing to pay for laboratory work was $24.25. Considering that thirty-eight households reported owing money for medical services obtained in the United States, with a minimum bill at $25.00 and a maximum bill at

$10,700.00, these findings on ability to pay are important to consider in planning future types of public and privately-subsidized medical insurance programs.

Marginal Local Political Power of Farmworkers in Homebase Areas

Both migrating and non-migrating farmworkers face other more subtle structural barriers that affect their health and potential and realized access to medical care services. Mecca is a community in which both migrating and non-migrating farmworkers are homebased. In addition, other farmworkers migrate to Mecca during the spring. As a community health worker, I had the opportunity to interact with all three groups of farmworkers extensively. I came to understand that most farmworkers, whether temporary or year-round residents, recognize that many of the inequities that they experience are due to a lack of political power, to discrimination, and to the vulnerability of the agricultural market.

Tarascan-speaking farmworkers reported more barriers than Spanish-speaking farmworkers. In Mecca, they are paid less, they endure overt discrimination, and they are housed in run down privately-owned residences that are in need of repair. Since many are undocumented, they do not qualify for subsidized housing and subsidized day care, and they are ineligible for the regular Medi-Cal program. They also live farther away from the primary health care clinic and are more likely to report that medical practitioners do not understand their medical needs. All these factors affect potential and realized access to medical services.

Since their non-citizenship prevents most Mecca residents from voting, plans to improve basic services are usually made by those who do not live there. The marginal political power of Mecca residents indirectly affects their health and access to medical

services. For example, as of 1999 there was no system of drainage in Mecca. Year round, whether it rains or not, huge puddles of stagnant water breed insects that have the potential to carry vector-born illnesses to Mecca residents. Moreover, most community members want more of a police presence in Mecca for improved response time and to deter crime. However, there continues to be no police sub-station out in this area. Although there is a fire station in Mecca, no paramedics are based near Mecca. This increases the time for paramedics to respond to an emergency in Mecca and impacts potential access to emergency services for all Mecca residents, including farmworkers and their family members. This long response time also affects the quality of the care they receive and increases the chance for a poor outcome in traumatic injuries. This situation is especially critical for farmworkers involved in incidents of pesticide poisoning. Mecca is also known for its abundance of flies but the number of flies. The number of flies increases exponentially during the hot months of the harvest season when it is not uncommon for growers to leave crops, especially melons, rotting in the fields. Such fields are literally across the street from hundreds of people living in apartments in Mecca.

Minimal public transportation is another problem with health and safety consequences and it may result from minimal political influence. In a town that hears the roar of trains at least hourly, there is no longer a passenger train that connects Mecca to nearby Indio. There also used to be a Greyhound bus station in Mecca. Nowadays Greyhound drops passengers off on the highway just outside of Mecca. Passengers then have to cross the highway, pass over several sets of railroad tracks, and then walk through bushes to get into Mecca. As for public city transportation, the Sunline bus has

recently expanded service in and out of Mecca. But unlike stops in other towns served by the Sunbus, only one of the ten stops in Mecca has a bench or any type of shady covering. Considering the fact that Mecca has temperatures that are over 85 degrees Fahrenheit for most of the year, just standing and waiting for the bus can be a dehydration risk, especially for sick and elderly bus patrons. A greater inconvience is that the bus does not stop in front of the health clinic. Inadequate transportation to medical clinics in and outside of Mecca impacts realized access to medical services for farmworkers who live year-round in Mecca, as well as those who migrate to Mecca.

In sum, the lack of an infrastructure for drainage, the lack of a paramedical and police sub-station, the rotting agricultural produce, the insect problem, the bus stops without shelters, and the slow response time by government officials, are in part a function of the marginal political influence of the non-citizen, non-voting population. In other words, to capture the attention of local, state, and federal officials it takes excessive time and effort from those tackling the problems in Mecca. So despite the accomplishments of increased low-income housing, and the establishment of a medical clinic and the reality of a booming agricultural economy, there are significant issues that still need to be addressed in this farmworker community.

Implications for Medical Social Scientists

At this point it is important to discuss how applied social scientists can most effectively address limited access to medical services among California farmworkers since the political economy of health perspective leaves open the opportunity for researchers to have an impact on the communities most affected by their research. It is important to disseminate the information gained by this research, not only to academia,

but also to medical providers, county administrators, local school and political officials, housing authorities, and most importantly farmworker families and their advocates. Each group has different sets of standards and expectations. So in order for this research to effectively contribute to the debate on access to medical services among California's farmworkers, it has been important to become well-connected with those providing private, public, educational, and charity services. For example, I gave presentations to Healthy Start, the Mecca Community Council, Clinicas de Salud del Pueblo (CMHC), the Coachella Valley Housing Coalition, the Mecca Elementary School, and Migrant Head Start parents. I revealed to them what my research was indicating and I asked for their opinions. They usually were excited, gave me referrals, and utilized my research in their planning (Mecca Community Council & the Mecca Health Clinic). This type of participation and communication is a way for the researcher to be held accountable at the local level. It also familiarizes people with what medical social scientists do.

Even though this may not be easy, applied medical social scientists should engage in public health analysis. Margaret Boone, an applied medical anthropologist, clearly encourages other applied medical anthropologists to engage in policy analysis. Boone argues in a 1991 manuscript that

> Medical anthropologists who remain interested only in medical conditions and who fail to consider how the poor and elderly interface with government bureaucracies to obtain needed health care may succeed as anthropologists but not as expert participants in the public policy process. For a medical anthropologist to research the social and cultural bases of a particular disease or condition is to stop short of involvement in domestic health policy. The medical anthropologist must

> clearly outline the implications of the social and cultural factors for health care, not just health.... If medical anthropologists want to become involved in policy, then they should go beyond the disease into a consideration of the system that treats it (Boone 1991).

I agree with Boone that medical social scientists should engage in policy analysis, especially if their research is applicable to a current debate.

Summary

Overall, access to health care is understood in this research as a social process determined by the characteristics of the health care system and its potential users (Singer 1994). Characteristic of political economic analysis, this research endeavor has concentrated on examining access as it relates to inequitable distribution and utilization of medical care services in the rural areas of California. The following chapter summarizes key findings and suggests health care policy changes that could improve access to care.

CHAPTER 8: SUMMARY AND CONCLUSIONS

The research findings demonstrate that structural access variables inherent in public and private health insurance programs severely limit access to medical services. These forces, which are embedded in socio-cultural processes, explain who has access to medical services, why they do so, what type of care they receive, how they access it, and where they go for these services. Unique to this research endeavor is an examination of health care access under two labor patterns: when farmworkers migrate and when they do not. This research effort investigates how public, private, and charity health policy regulations affect access to medical care for farmworker women, their children, and their spouses. Cultural factors may add to the problem of access to medical services for migrating and non-migrating farmworker households, but cultural beliefs are not the main focus of this research effort.

Limitations of the Study

The aims of this research project were to promote an understanding of the health experiences of farmworker households living and working in modern day agriculture. The findings of this study are limited to the specific group of migrating and non-migrating farmworker households homebased in the desert areas of the Southwest. It is important to emphasize that the distinction between migrating and non-migrating farmworkers in this study is based on the unique characteristics of this stream. Migrant labor streams in different states may not be comparable since potential access to services will be different based on the resources allocated to upstream and downstream locations. It must also be recognized that most households targeted in the study were able to find decent housing in their homebase residence. More specifically, those families who

qualify for subsidized housing represent a small group of farmworkers who overall have a better standard of living. The housing facilities where most interviews were conducted are modern, include on site laundry, and are safe. Therefore, my sample is biased towards more privileged farmworker families. Living closely among other farmworker families, helps keep them well-informed about services available to them. Although a few household members were undocumented, most farmworkers in this sample qualify for some level of public services. Despite the reality that my sample may not represent the plight of all California farmworkers and their families, the interviewees still reported significant problems when it came to access to health care.

Policy Research Findings

As noted, this project focuses on the assessment of health services for a portion of California's working poor farmworkers and their families residing in isolated rural communities. There are a number of key findings with great significance for California Health Policy:

1. Access to both public and private health care coverage is greater for populations of resident, documented immigrants with stable living patterns. The population studied is not a typical farmworker population since many households sampled reside in subsidized government housing units where the head of household must prove a legal immigration status.
2. Dental and vision coverage is rare for both migrating and non-migrating farmworkers.

3. Only a small percentage of families with medical insurance has coverage for all members. This is the case both for families with private insurance, where dependent coverage may be limited, and for families covered by public programs, largely due to the mixed legal status of different family members.
4. Most farmworker families will seek treatment when they are very sick, regardless of insurance coverage. However, farmworkers will delay treatment and not seek preventative care– leading to higher costs– when they have minimal insurance coverage or are unable to pay for private providers or meet insurance deductibles.
5. Access to public coverage is restricted by difficulties in transferring caseloads and eligibility information from one county to another. Distances from specific providers restrict potential and realized access to private insurance, especially for migrant households.
6. In this population, there is a higher use of public medical insurance among children than among adults (67 percent of children but only 13 percent of adults).
7. Among those farmworkers interviewed who are eligible for public health insurance coverage, actual use is restricted by lack of awareness of these programs and by difficult and confusing application processes.
8. Access to care for non-life threatening emergencies and tertiary/specialized care can be restricted by each county's interpretation of its legal responsibilities to families covered by Medically Indigent Adults and limited scope (restricted) Medi-Cal. This impacts both migrating and non-migrating farmworker households.
9. Requirements for quarterly re-certification under the Medically Indigent Adults Program and Medi-Cal are major obstacles to realized access to medical care by this

farmworker population. In addition, migrant households need to re-apply in each county where they work in order to continue coverage.

10. New legal immigrants, who prior to the enactment of federal welfare reform legislation would have been eligible for public medical insurance, will face a confusing set of federal and state requirements regarding options for public benefit coverage. New laws restrict certain immigrants from applying for specific types of public coverage.
11. Farmworkers in this study are willing to pay premiums averaging $35 per month for coverage, and pay modest co-pay fees for provider and ancillary medical services.
12. Although there is a wide range of private insurance programs available in this unique farmworker population, the high deductibles, the caps on coverage, and the limitations on dependent coverage restrict the use of many of these programs.
13. Several widely-available private insurance plans for this population offer full coverage when the worker goes to Mexico to receive care; this benefit restricts access for some but is appreciated by those farmworkers who can easily access services in Mexico.
14. Occupational and housing conditions appear to place farmworkers at risk for a variety of health problems including intestinal disorders, exposure to chemicals, occupational injuries, and various infectious conditions.
15. Migrating farmworkers appear to be more vulnerable than non-migrating farmworkers to certain types of health problems, including intestinal ailments, head lice, and infectious diseases spread in close living quarters, and also to conditions resulting from poor diet largely composed of fast and junk foods.

16. Substance abuse, including heavy alcohol consumption, appears to cause and aggravate the health and well being of the user as well as his or her family members.
17. There are groups of Mexican national farmworkers working in California who reside on Native American reservation lands without access to care or coverage but with extensive health concerns related to their extremely poverty-stricken, marginalized living conditions.

Overall, these findings suggest some recommendations for health care policy reforms in California that could improve access to medical services among California farmworkers.

Recommendations

Overall, we need to improve the Medi-Cal application and eligibility process and to fund and train community health workers to educate farmworkers on medical insurance programs. We should establish committees to examine bi-national medical insurance programs and to address public health issues of Mexican Nationals living on Native American lands. We also need to direct adequate resources to improve rural medical education in California, and to consider the consumer-service aspects of providing medical services to farmworkers in rural areas of California. The following section examines these suggestions in greater detail.

(1) Improve the Medi-Cal and Denti-Cal Services

The Medically Indigent Adult Program and Medi-Cal eligibility processes are cumbersome. Applications are long and poor translations are done in Spanish. Files are purged and thrown away. Clients have to fill out the same forms over and over again. Simplify the process. Shorten the application by determining eligibility based on a household's income tax return. Moreover, people on Medi-Cal should not have to reapply

every 45 days. Reduce the paperwork and the burden on clients. Determine eligibility for MediCal once a year. If a client migrates to another county, the case should be transferred and his or her eligibility along with it. Unless they re-apply, they are ineligible for services in another county. The MIA and Medi-Cal eligibility should be statewide and not limited to a specific county.

Managed Medi-Cal imposes further geographic restrictions on permitted providers. Plan members can choose only one specific facility within a county where they and their dependents can seek services. One solution would be to exclude farmworkers and other rural residents from these new provisions.

Farmworker household income varies greatly over the year. Since benefits are tied to income, farmworker families usually lose Medi-Cal or MIA benefits during peak season. Allow for continuity of care by offering clients the option to pay monthly premiums if a farmworker family's income rises. Just increase the share of costs instead of kicking them off Medi-Cal.

Expand the Denti-Cal program and provide additional funding for dental clinics in rural areas serving large concentrations of farmworkers. Allocate additional funding for mental health services, including substance abuse treatment programs, in rural areas.

There are at least 20 publicly-subsidized health programs that various segments of the farmworker population can apply for. These programs represent a patchwork of uncoordinated programs that have separate administrative processes and confusing and sometimes conflicting eligibility requirements. Streamline this process and make more vigorous efforts to advertise these programs to the target population.

(2) Fund and Train Community Health Workers about Medical Insurance

Farmworkers need a direct liaison between them, clinic providers, and other advocacy groups. Train and adequately fund community health workers to understand both private and public medical insurance programs in California, so they in turn, can teach farmworkers and their family members. Training community health workers in health education simply is not enough. I predict that this type of program were actually implemented, this intervention would have a profound impact on increasing the utilization of health care services among farmworkers in California.

(3) Establish a committee to examine binational medical insurance practices

Binational efforts between Mexico and the United States need to be strengthened. Private US-based medical insurance companies such as Transwestern and Western Growers pay 100 percent of medical costs if farmworkers go to Mexico for medical care. There are many consequences when these types of insurance programs operate on both sides of the border. A binational commission needs to be established to examine the potential consequences when private US medical insurance plans operate in Mexico. Private health foundations are beginning to develop this idea.

(4) Establish a non-government committee to address public health issues of Mexican Nationals living on Native American lands

A dialog needs to be started between Native Americans, farmworkers, and their advocates to address the public health issues when farmworkers rent out Native American land. Currently, hundreds of mostly undocumented farmworkers rent out Native American land. Unless married to a Native American, most are not eligible to use the nearby Indian Health Services. The public health care implications are enormous.

(5) Direct adequate resources to improve rural medical education in California

Medical schools, public health schools, schools of social science, and schools of computer science need to come together to effectively automate medical data for Community and Migrant Health Centers. Require medical students, social workers, and public health nurse practitioners to conduct community-based census studies as part of their graduation requirements. This may increase interest in practicing in a rural area. Develop a *comprehensive* rural residency program in California for primary care internists interested in rural care. Currently, this type of residency training does not formally exist in the southeastern and northern portions of California.

(6) Consider ambulatory and urgent care clinics in isolated rural areas

This problem needs to be addressed. Farmworkers utilize services primarily when they are very sick. Perhaps the concept of a primary health care clinic needs to be modified. Farmworkers need urgent care or ambulatory medical clinics in addition to preventative primary health care clinics. Perhaps the very design of community clinics in isolated rural areas needs to be re-examined.

(7) Consider the consumer-service aspects of providing medical services

This research revealed that farmworkers absolutely detest waiting for long periods of time for a medical appointment. They expect to be attended to promptly; the average waits at the primary health care clinics range between one hour and eight hours. Reduce the wait by expanding the clinics and providing additional incentives to medical providers who practice in underserved rural areas.

Figure 8.1 on the following page summarizes these recommendations.

FIGURE 8.1

SUGGESTIONS FOR HEALTH CARE POLICY REFORM IN CALIFORNIA

(1) IMPROVE THE MEDI-CAL & DENTI-CAL SERVICES

Shorten the application.

Determine eligibility once a year, not every 45 days.

MIA and Medi-Cal eligibility should be statewide– not by county.

Drop geographic restrictions for farmworkers on managed Medi-Cal.

Give clients the option to pay a share of costs if their income rises.

Streamline the 20-plus public-subsidized health programs.

(2) FUND AND TRAIN COMMUNITY HEALTH WORKERS TO ASSIST FARMWORKERS IN APPLYING FOR AND USING PRIVATE AND PUBLIC MEDICAL INSURANCE.

(3) ESTABLISH A COMMITTEE TO EXAMINE BINATIONAL MEDICAL INSURANCE PRACTICES.

(4) ESTABLISH A NON-GOVERNMENTAL COMMITTEE TO ADDRESS THE PUBLIC HEALTH ISSUES OF MEXICAN NATIONALS LIVING ON NATIVE-AMERICAN LANDS.

(5) DIRECT RESOURCES TO IMPROVE RURAL MEDICAL EDUCATION IN CALIFORNIA.

(6) IN ISOLATED RURAL AREAS, THERE IS A NEED FOR URGENT CARE AND/OR AMBULATORY MEDICAL CLINICS.

(7) CONSIDER THE CONSUMER-SERVICE ASPECTS OF PROVIDING MEDICAL SERVICES.

CONCLUSIONS

Unless dramatic structural changes in the agricultural labor force occur, California farm labor will continue to be provided by new immigrant groups that will face the same barriers as previous workers. The 1990s were characterized by an anti-immigrant sentiment, but as we approach the new millennium, we will see increasing numbers of non-Spanish speaking indigenous laborers whose origins are in Southern Mexico and Central America (Bade 1999, Kearny 1987). In some ways, agricultural work is becoming more complex and requires an increasingly sophisticated and educated work force. New immigrant farmworker will continue to need services.

For farmworkers in this study, realized access to medical services is limited regardless of insurance status. Whether insured or not, one's ability to pay for medical services in large part determines whether or not these services will be used. Farmworkers and their family members are often unaware of a variety of services that are available to them. Although private and charity services have their limitations, some programs do try to help out a family in critical need of services. This manuscript concludes with the a list of resources for those interested in the health care of farmworkers and their families in Figure 8.2.

FIGURE 8.2: RESOURCES FOR FARMWORKERS

INTERNATIONAL PROGRAMS

World Health Organization

Pan American Health Organization

International Labor Office

NATIONAL LEVEL PROGRAMS FOR FARMWORKERS

Harvest For Health

Migrant Clinicians Network

Farmworker Justice Fund

National Center for Farmworker Health

Julian Samora Research Institute

Migrant Health Program

Migrant Education

CALIFORNIA PROGRAMS FOR FARMWORKERS

California Rural Health Care Policy Council

California Endowment

Latino Coalition for a Health California

Medi-Cal Policy Institute

California Primary Care Consortium

California Healthcare Foundation

Office of Migrant Services

California Program on Access to Care, University of California

California Institute for Rural Studies

Employment Development Department

UCMEXUS

United Farmworkers

LOCAL INITIATIVES FOR FARMWORKERS

Rota Care Program

Lideres Campesinas

Coachella Valley Health Care Connection & Coachella Valley Housing Coalition

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APPENDIX 1: Household Survey of Farmworkers: Potential & Realized Access Questions

Número de entrevista___ NV___ PDC ___ CJ__ Trailer _ Casa ___Mecca Village___
Thunderbird___ Other ____

Parte 1: Primero tengo que obtener alguna información general de su familia. con el fin de relacionar estos datos con otras respuestas. First. I need to gather general information about your family.

Fecha-Date / / Hora-Hour ____________

1. ¿Cuánto tiempo ha vivido usted en esta comunidad (aquí)? How long have you lived here?
Años Totales/Total years ______ Semanas este año/Weeks this year_________

2. Gender/Sexo: M F Pareja/Couple together

3. ¿Cuál es su estado civil? What is you civil status?

___ soltero/a (single)___ casado/ a (married) ___ viudo/a/(widowed)
___ divorciado/a ___ separado/a/(separated) ___ arrejuntado/union libre

4. Dígame solamente su nombre. no necesita decirme su appellido. Please tell me only your first name. ¿Cuántos años tiene usted ¿cuáles son las edades de sus niños? How old are you? How old are each one of your children?

ID woman _________________ Edad ___ Niños Edades ___ ____ ____
ID man __________ Edad ___ ___ ___ ____ ____ ____

¿Dónde nació usted?_________________________
¿Dónde nació su companero?___________________
¿Dónde nacieron sus hijos?____________________

5. ¿Cuál es el primer idioma que aprendió? First language that you learned?
Inglés _____ Español_____ Mixtec______Otro______
¿Puede leer Español? Sí___ No ___ ¿Puede escribir Español? Sí ___ No ____
¿Puede leer Inglés? Sí___ No ___ ¿Puede escribir Inglés? Sí___ No ___

6.Educación: ¿Cuál fue el último grado/año que usted completo en la escuela?

años
1___ ninguna educación formal/no formal education
2___ algo de escuela primaria/some elementary school
3___ terminó la primaria/completed elementary school
4___ algo de escuela secundaria/ some junior high school
5___ terminó la secundaria/completed junior high school
6___ algo de la preparatoria/ some high school
7___ terminó la preparatoria /completed high school
8___ algo de colegio/some community college
9___ terminó AA/completed community college degree
10___ algo de universidad/completed some University
11___ terminó la universidad/completed the University
12___ estudios de post grado/post graduate study
13___ escuela técnica/technical school ¿Dónde? US México

¿Cómo se llama su compañía? Who is your employer? él______________________
¿Cómo se llama su compañía? Who is your employer?ella ____________________

Parte 2: Me gustaría hacerle unas preguntas sobre su trabajo en el campo.
I would like to ask questions about your work in the fields.

7. Homebase __________ ¿ Qué ciudad/pueblo usted considerá su hogar?
What city do you consider your homebase?

8. ¿Emigró en 95? Sí No. 9. ¿Emigró en 96? Sí No 10. ¿Emigró en 97? Sí No ¿98? Sí No
¿Con quién viaja?_________ con la familia _____ solo el esposo/a___ solo hijo/a____
con su niños______ sin sus niños________ Otros______________________________

11. ¿Por favor, puede describir su ruta? Please can you describe your route.________________

12. ¿Está viajando la misma ruta para trabajar en el campo este año?
¿Va hacia el norte? Are you traveling the same agricultural route this year? Sí No N/A

13. ¿Cuándo termine el trabajo aquí, a donde irá (a donde va ir)? N/A
When you finish work here, where will you go?_______________________________

14. ¿Cuántos años ha trabajado en el campo?_____ y su pareja_____
For how many years have you worked in agriculture?
15. ¿Con qué tipo(s) de cosecha trabaja usted? What type of crops do you work with?_________
16. ¿ Su esposo(a)/compañero(a) con qué tipo(s) de cosecha trabaja?____________________

Parte 3: En la tercera parte voy a preguntar sobre sus experiencias con seguro médico. In this third section, I am going to ask you about your experiences with medical insurance.

17. ¿ Usted y su familia tiene seguro médico? seguro de salud? aseguranza?
Do you and your family have medical insurance? Si No tiene seguro/NONE __________
* Si tiene información sobre su seguro, ¿puedo verlo (una tarjeta, foleto, cuentas)?
* If you have information about your insurnace, can I see it? such as a card, a pamplet, bills?

18a. Tipo de seguro médico/type of medical insurance:
Public Health Coverage:
____ Children's Crippled Service ____ Child Health and Disability Prevention (CHDP)
____ MISP: Indigent Medical Services/County based program ___ Medi-Cal ER adult
____ Managed Care Medi-Cal : ___ IEHP ___ La Molina ___ Other:____________
____ Medi-Cal complete-adult ____ Medi-Cal pregnancy only
____ Medi-Cal ER-child____ Medi-Cal complete-child
____ Medi-Cal Restricted Benefits Program ____ Adult ____ Child
____ Some kids in family have Medi-Cal while others do not
____ SSI
____ Access Plan of Arizona ____ Medi-Care ____ Worker's Comp Other _____

Private Insurance:
____ Health Net ____ Health Net Select _____ SMA Healthcare
____ Western Growers ____ PTA-Arizona ____ Kaiser Permanente
____ Robert F. Kennedy Farmworkers Medical Plan ____ Great West Health Plan
____ Pru Care HMO ____ Metra Life ____ United Agriculture
____ Pan Pacific Benefit & Administration ___ Golden Ace Farms Group # 1097___
____ Transwestern ____ Blue Cross ____
____ Doesn't know name of private insurer
____ Combination of public and private health insurance. Other____________________

18b. ¿En este momento, quién en su familia tiene seguro de salud, de cualquier tipo?

madre none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

padre none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

otro adulto 1 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

otro adulto 2 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

niño 1 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

niño 2 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

niño 3 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

niño 4 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

niño 5 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

niño 6 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

niño 7 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

niño 8 none Medi-Cal MediCare, SSI, CDHP, Denti-Cal
Other public__________ Private ______________________
edad____

19. ¿ Quién es el proveedor de su seguro? Who provides you with insurance?__________

20. Algunas preguntas sobre su seguro. Some questions regarding your insurance.
¿Tiene un copago? Do you have a copayment? ______ ¿Cuánto? How much? ____
¿Tiene un deducible? Do you have a deductible?______ ¿Cuánto? How much?____
¿Cuánto paga por medicinas? How much do you pay for medicine? ________
¿Cuánto paga por pruebas de laboratorio? How much for lab tests? _______
¿Cuánto paga (le cobran) por consulta? How much for an appointment? ______

21. ¿En este momento tiene una cuenta de servicios médicos que no ha terminado de pagar?
Do you currently have medical bills that you are still paying for? No Yes_________

22. ¿Qué le ha ocurido por falta de aseguranza médica?
(¿ Si alguien no tiene seguro médico, piensa usted que esa persona va a tener problemas recibiendo servicios médicos?) Has anything occurred because of a lack of medical insurance? _____

Parte 4 : En esta parte quiero preguntarle sobre sus experiencas con servicios médicos.
In this part I ask you about your medical experiences.

23. ¿Cuándo fue la ultima vez que solicitó atención médica para usted o para su familia? ¿Dónde?
Where was the last time that you or a member or your family solicited medical attention? México__ US ___ Nunca___

¿El médico hablaba español? Sí No
¿Habían otras personas en la clinica que hablaban español?__________ Sí No
¿Cómo fue la atención que recibió? ¿Cómo calificaría la atención que recibió? How did they treat you?
Excelente___ Muy buena ____ Buena ____ Regular ____ Mala _____
¿Cuánto pagó?_____ México____ US ___

24. ¿Cuándo fue la ultima vez que solicitó atención dental para usted o para su familia? ¿Dónde?
When was the last time you or a member of your family solicited dental care? Where?
México__ US ___ Otro______ Nunca____
¿El dentista hablaba español? Sí No
¿Habían otras personas en la clínica que hablaban español?___________ Sí No
¿Cómo fue la atención que recibió? ¿Cómo calificaría la atención que recibió?
How did they treat you?
Excelente___ Muy buena ____ Buena ____ Regular ____ Mala _____
¿Cuánto pagó?_____

25. ¿Cuándo fue la última vez que solicitó atención óptica (para los ojos) para usted o su familia? ¿Dónde?
When was the last time you or a member of your family solicited for eye care? Where?
México__ US ___ Otro ______ Nunca__
¿El médico hablaba español? Sí No
¿Habían otras personas en la clínica que hablaban español? Sí No
¿Cómo fue la atención que recibió? ¿Cómo calificaria la atención que recibió? How did they treat you?
Excelente___ Muy buena ____ Buena ____ Regular ____ Mala _____ ¿Cuánto pagó?____

26. ¿Cuándo fue la última vez que solicitó atención quiropráctica o de un sobador para usted o su familia? ¿Dónde? When was the last time that you or a member of your family saw a chiropractor? Where?
México__ US ___ Otro ______ Nunca___
¿El médico hablaba español? Sí No
¿Habían otras personas en la clínica que hablaban español? Sí No
¿Cómo fue la atención que recibió? ¿Cómo calificaría la atención que recibió?
Excelente___ Muy buena ____ Buena ____ Regular ____ Mala _____
¿Cuánto pagó?_____________

27. ¿En los años 1995,1996,1997, 1998 usted o un miembro de su familia ha ido a una sala de emergencia?
Did you or a member of your family go to an emergency room? No Sí,Yes
¿Dónde, Where?_______ ¿Cómo fue la emergencia? How did the emergency happen?_______
¿El médico hablaba español? Sí No
¿Habían otras personas en la clínica que hablaban español? Sí No
¿Cómo fue la atención que recibió? ¿Cómo calificaría la atención que recibió?
Excelente___ Muy buena ____ Buena ____ Regular ____ Mala ____ ¿Cuánto pagó?____

28. ¿Durante los años 1995,1996,1997,1998 le han negado atención médica a usted o algún miembro de su familia? In 1995,1996,1997,1998 were you / family member denied medical care?
No Sí,Yes ¿Cuándo? / ¿Por qué? Why?

29 . ¿En los años 1995,1996,1997, 1998 encontró dificultades para recibir servicios médicos (para recibir atención médica)? In 1995,1996,1997, 1998 did you encounter difficulties accessing services? No Sí.

30.¿En qué tipo de lugar? In what type of place? ___ doctor privado ____ clínica
_____ sala de emergencia _____ hospital ___ curandero ____ farmacia otro/other ___________
¿Por qué piensa así? Why do you think this is so?

31. ¿En los años 1995,1996,1997,1998 buscó servicios médicos (ayuda médica) cada vez que no se sintió bien? In 1995,1996,1997,1998 did you see a doctor each time when you were not feeling well? Sí No
No go to 32.

32. ¿Cuáles fueron sus razones para no buscar atención médica, a pesar de sentirse mal?
What were the reasons that you didn't seek medical attention even though you were not feeling well?

33. ¿En qué temporada ustedes necesitan más los servicios médicos? ¿Y sus hijos? ¿Generalmente, cuáles son los meses del año donde ustedes necesitan atención médica más frecuentamente? In a years time what time or season do you need services the most? What about your children?

34. ¿Según su propia experiencia, usted recibe atención médica cuando más la necesitan?
Can you receive medical services when you need them the most? Sí,Yes No

35. ¿En los años 1995,1996,1997, 1998 mientras trabajaba en los EE.UU fue a México para recibir atención médica? In 1995,1996,1997,1998 while you working in the United States did you go to Mexico for medical attention? No Sí, Yes. ¿Cuál fue el problema? What was the problem?

36. ¿Qué servicios usó en México?What services did you use in Mexico?
farmacia/botánica/Dr./clínica/hospital/curandero/espiritualista/sobador/otro?
¿Cómo fue la atención que recibió? ¿Cómo calificaría la atención que recibió?
Excelente___ Muy buena ____ Buena ____ Regular ____ Mala _____ ¿Cuánto pagó?_______

Traditional Medicinal Teas & Plants

37. ¿Usted se cura en casa con medicinas caseras (naturales)? Sí No ¿Cuántos tés se usan? ____
___abango___ahuehuete___ ajenjible entero ___ ajenjo ___ ajo___ albahacar ___ alfalfa ___ alucema
___ alumbre ___ anis ___ anis en grano ___ anis estrella ___ apio ___ arnica ___ axocopaque ___ azahar
___ azafran ___ azufre ___ barbas de elote ___ B – Tina ___bardana ___ boldo ___ borraja ___ bronco te
___ cancerina (asclepias curassaviea) ___ canela ___ canelita ___ canutillo ___ capitaneja
___cardo santo (argemone mexicana) ___ cascara sagrada ___ cebada ___ cebolla ___ cedron
___ chanchalagua ___ chaparro amargo ___ chia ___ cocolmeca ___ cola de caballo
___ confrey ___ copalquin ___ cuachalalate ___ cuassia ___ damiana ___ diabetina ___ diente de leon
___ eneldo ___ encino ___ epazote de comer ___ epazote de zorrillo ___ estafiate ___ eucalipto
___ garanona ___ gobernadora ___ golondrina ___ gordolobo ___ gotukola ___ guarumbo
___ gumbo file ___ hojas de mesquite ___ hoja de uva ___ hojasen ___ laurel ___ linaza ___ llanten
___ malabar ___ manrrubio ___ manzo raiz ___ manzanilla ___ manzanis ___ matarique
___ mejorana ___ menta ___ miel y limon ___ mostaza negra ___ nogal ___ nopal ___ nuez moscada
___ oregano ___ palo brazil ___ palo huaco ___ pasiflora ___ perejil ___ pinguica fruta ___ poleo
___ prodigiosa ___ quina roja ___ raiz de altem ___ rinosan ___ romero ___ rosa de castilla
___ rubarbo ___ ruda ___ sauco ___ salvia ___ santa maria ___ savila ___ siete azahares
___ te de indio ___ te japones ___ te diosa ___ te de limon ___ te maravilloso ___ te negro
___ te soma ___ tila estrella ___ tila hoja ___ tomillo ___ torongil ___ tronadora ___ uña de gato
___ valeriana ___ yerbabuena ___ yerba del cancer ___ yerba del golpe ___ zarzaparilla ___ zendo

Parte 5: En esta parte quiero preguntarle sobre sus opiniones sobre la salud de los trabajadores del campo y los servicios para ellos.

General Health Problems
38 a. ¿Cuáles son los problemas de salud más importantes que tienen los trabajadores del campo? What health problems do farmworkers experience?

38 b. ¿ Usted tiene problemas de la salud por trabajar en el campo? Sí No
____ lastimaduras ____ manchas en la piel ___ quemaduras del sol
____ problemas respiratorios ____ cortaduras (cuts) ____ fracturas
____ reumas/artritis ____ infecciones de la orina ___ problemas de los riñones
____ alergias ____ problemas por causa de los insecticidas ___ dental
____ hambre cuando está trabajando ____ sed cuando está trabajando otros problemas ______

38 c. ¿ Hay baños en el campo donde usted trabaja? Sí ___ No ___
¿ A usted se le permite usar el baño cuando es necesario? Sí ___ No ___
¿ A usted se le permite lavarse las manos despues de trabajar con pesticidas? Sí ___ No
¿ Hay jabón? Sí ___ No ____
¿ A usted se le permite lavarse las manos antes de comer? Sí____ No ___
¿ Hay agua para beber mientras estas trabajando en el campo? Sí ___ No ____

Migrating Conditions:
Ahora le voy a preguntar sobre los servicios de salud que usted y su familia reciban cuando están emigrando de un lado a otro para realizar su trabajo en el campo.

39. a. ¿Qué tipos de problemas de salud tiene usted (y sus hijos) cuando están emigrando (viajando) ? ¿Qué clases de enfermedades usted y su familia padecen por estar moviéndose de un pueblo a otro? What kind of health problems do you and/or your children have while you are migrating?

39 b. ¿ Cuándo ustedes estan emigrando por el campo, sabe dónde están las clínicas de salud en la comunidad? Sí___ No ___ ¿Dónde? ______________________________
¿ Sabe dónde queda la sala de emergencia? Sí__ No ___ ¿Dónde? _______________
¿ Sabe dónde puede comprar medicinas? Sí ___ No ___ ¿Dónde? ______

39 c. Mientras ustedes estan yendo de un pueblo a otro, ¿tienen ustedes problemas de transporte cuando un miembro de su familia necesita ir a ver un doctor? Sí No

39 d. ¿Dónde vive cuando ustedes estan viajando por el campo? departamento_____
labor camp/campo de trabajo _____________ temporary migrant family project/
projecto de casas para familias_______________private house/ casa privada____
room______ garage______ trailer______ hotel_______ car_____ Otro____
¿ Hay agua? ____ ¿electricidad? _____ ¿Hay un baño para cada familia? Sí__No __

39 e. ¿Piensa que los servicios médicos son accesibles durante el tiempo cuando ustedes están emigrando por motivos de su trabajo? Do you think medical services are accessible while you are migrating for farmwork? Sí No
39 f. ¿Piensa usted que los trabajadores del campo necesitan servicios médicos especiales? Sí No ¿ Me puede explicar?

Non-Migrating Conditions
Ahora le voy a preguntar sobre los servicios de salud que usted y su familia reciben en su lugar permanente de residencia (aquí en Mecca).

40 a. ¿Qué tipos de problemas de salud tiene usted (y sus hijos) cuando no están emigrando (cuando están viviendo aquí)? What kind of health problems do you and your kids have while you are not-migrating?

40 b. ¿ Cuándo ustedes no estan emigrando, sabe dónde están las clínicas de salud en su comunidad?
Sí___ No ___ ¿Dónde? ______
¿ Sabe dónde queda la sala de emergencia ? Sí__ No ___ ¿Dónde? ________
¿ Sabe dónde puede comprar medicinas? Sí ___ No ___ ¿Dónde? ______
40 c. ¿Tienen ustedes problemas de transporte cuando un miembro de su familia necesita ir a ver a un doctor? Sí No
40 d. ¿Dónde vive cuando no están viajando por el campo por motivos de trabajo?
¿ Dónde vive ahora?
Mecca___ Yuma ___ Otra ________
Apartment Complex ____________ NV__ PDC ___ CJ___
Trailer __ Casa ___ Garage ______
¿ Hay agua? ____ ¿electricidad? _____ ¿Hay un baño para cada familia? Sí__No __
40 e. ¿Piensa que los servicios médicos son accesibles cuando no están emigrando? Do you think medical services are accessible while you are migrating for farmwork?
40 f. ¿Piensa que los servicios médicos son accesibles en este comunidad? Sí No
40 g. Existen dos tipos de familias en el campo. Unas que emigran de pueblo a pueblo y otras que se quedan toda el año en un solo lugar. ¿Usted cree que la atencion médica que reciben las familias que se quedan en un solo sitio es diferente a aquella que reciben las familias que emigran durante el año? ¿ Me puede explicar?

Part 6: En esta parte quiero preguntarle sobre sus ideas sobre el mejoramiento de los servicios médicos en el estado de California.
41. ¿Suponiendo que usted no tiene ningún tipo de seguro, qué precio (o cuánto) piensa usted que es razonable pagar por una consulta con un médico familiar? If one does not have health insurance, what price do you think is fair to pay for a family medicine consult?
$1___ $5 ___ $10___ $15___ $20___ $25___ $30___ $40 ___$50___ $60___ $70___ $80__ $90___
$100 ____ $ 125 ____ $ 150 ____ $200 _____ $250 ____ $300____

42. ¿Suponiendo que usted no tiene ningún tipo de seguro, qué precio (o cuánto) piensa usted que es razonable pagar por una consulta con un médico especialista? If one does not have health insurance, what price do you think is fair to pay for a medical consult with a specialist?
$1___ $5 ___ $10___ $15___ $20___ $25___ $30___ $40 ___$50___ $60___ $70___ $80__ $90___
$100 ____ $ 125 ____ $ 150 ____ $200 _____ $250 ____ $300____

43. ¿Suponiendo que usted no tiene ningún tipo de seguro, qué precio (o cuánto) piensa usted que es razonable pagar por una visita a una sala de emergencia? If one does not have health insurance, what price do you think is fair to pay for a visit to the emergency room?
$1___ $5 ___ $10___ $15___ $20___ $25___ $30___ $40 ___$50___ $60___ $70___ $80__ $90___
$100 ____ $ 125 ____ $ 150 ____ $200 _____ $250 ____ $300____ $500___
$1000____ $1000+ _____

44. ¿Suponiendo que usted no tiene ningún tipo de seguro, qué precio (o cuánto) piensa usted que es razonable pagar por una receta de medicina? If one does not have health insurance, what price do you think is fair to pay for a medicine? Pay whatever it costs _____
$1___ $5 ___ $10___ $15___ $20___ $25___ $30___ $40 ___$50___ $60___ $70___ $80__ $90___
$100 ____ $ 125 ____ $ 150 ____ $200 _____ $250 ____ $300____

45. ¿Suponiendo que usted no tiene ningún tipo de seguro, qué precio (o cuánto) piensa usted que es razonable pagar por una prueba de laboratorio? If one does not have health insurance, what price do you think is fair to pay for a laboratory test?
$1___ $5 ___ $10___ $15___ $20___ $25___ $30___ $40 ___$50___ $60___ $70___ $80__ $90___
$100 ____ $ 125 ____ $ 150 ____ $200 _____ $250 ____ $300____

46. ¿Suponiendo que usted no tiene ningún tipo de seguro, qué precio (o cuánto) piensa usted que vale la pena pagar por seguro médico familiar cada mes? Sí__ No ___

47. ¿Cuánto puede su familia pagar cada mes por seguro médico general para la familia?
$1___ $5 ___ $10___ $15___ $20___ $25___ $30___ $40 ___$50___ $60___ $70___ $80__ $90___
$100 ____ $ 125 ____ $ 150 ____ $200 ____ $250 ____ $300____
de dentista______ servicios ópticos____ total_____ individual_____ familia_____

48. Para una trabajadora del campo, ¿Qué día o días y qué horas son las más convenientes para acudir (ir) a una clinica cuando uno está enfermo? _____en la mañana_____ en la tarde ____ en la noche ________
Lunes__ Martes ___ Miércoles ___ Jueves ___ Viernes____ Sábado____ Domingo___

49. ¿Qué tipos de medicos quiere usted ver más en una clínica? médico familiar____ pediatra ____
medico obstetra ____ médico especialista _____ qué tipo____________
50.¿ Qué tipos de servicios quiere ver más en las clínicas que no hay ahora? No sé
51. ¿Qué prefiere ver? un médico _____ médica_____ o no importa ______
52. ¿Cuántas horas está usted actualmente trabajando por semana? How many hours do you work in a given week? ______ ¿su compañero/a? ______
53. ¿Incluyendo a todos los miembros de su hogar, cuánto es el ingreso mensual en su casa? What is the monthly total household income? 0-500(250) _____ 500-1000 (750) _____ 1000-1500 (1250) _____
1500-2000 (1750) _____ 2000-2500 (2250) ______2500-3000 (2750)______ 3000-3500 (3250)______
3500-4000 (3750) _______ 4000-4500 (4250) ____ 5000 _______

54. ¿Recibe usted "food stamps" o estampillas para comida del gobierno?
Do this household receive food stamps? Si No 95__ 96__ 97_ 98__ Nunca

55. ¿Su familia recibe beneficios de desempleo cuando no hay trabajo de agricultura? Do you receive unemployment when there isn't agricultural work? No
Sí ___ Cuánto? ________ 95__ 96__ 97___ 98__

56. ¿Su familia recibe ayuda para familias con niños? Does your family receive any help for families with children? No Si 95__ 96__ 97___ 98__ AFDC: CalWorks ________ WIC ________

57. ¿Su familia tiene un carro? Does your family have a car? Sí___ No ___

58. ¿ Su familia usa transporte público? Does your family use public transportation?
no___ Greyhound____ SunLine_____ County Transit____ Metrolink_____

59. ¿Cuál es su estado migratorio? Sociopolitical status: MAC MI-CA. AZ MN
¿Y sus hijos? MA MI MN ¿Y su compañero/a? MA MI MN

60. ¿ En qué forma prefiere usted recibir información sobre servicios médicos? ___ folleto _____ radio
____ TV ____ periódico _____ Otra manera ___ todos _____

Part 7 Las nuevas leyes que afectan a los immigrantes.

61. ¿Usted sabe que ahora hay nuevas leyes que afectan a los immigrantes? Sí____ No___
62. ¿Usted cree que esas leyes afectan a usted y su familia? Sí____ No____
63. ¿Cómo les afectará a usted y su familia la nueva ley que elimina (limita) las estampillas de comida para aquellas personas que no son ciudadanos? ¿Qué hará usted?
64. ¿Cómo les afectará a usted y su familia la nueva ley que elimina (limita) el uso de MediCal?. ¿Qué hará usted?
65. ¿Ya que ha pasado esta ley, cómo piensa usted hacerle para recibir asistencia médica para usted y su familia? ¿Qué hará usted?
66. ¿Tiene otros comentarios que quisiera compartir conmigo?

APPENDIX 2: SPANISH TRANSLATION

FARM LABOR IN THE COACHELLA VALLEY

Interviewer: ¿No hay peligro de que la compañía de repente diga, ya no somos compañía sin aviso previo, y les quiten el seguro?
Male Farmworker: Sí.
Female Farmworker: O sea, a lo mejor no lo pueden hacer, pero lo hacen. Y como saben que la mayoría de las personas no saben las leyes como debería ser. Muchas veces no sabes la ley, sabemos lo que ellos nos dicen, o lo que ellos quieren que nosotros sepamos, no más, no exactamente. Si tú te pones a investigar bien y todo, tal vez te puedas defender, pero óyeme si son 50 trabajadores y nomás tú hablas....
Interviewer: ¿Te despiden?
Male Farmworker: Te despiden y ya. September 16, 1996

FARMWORKERS HOMEBASED IN MECCA, CALIFORNIA

Male Farmworker: El Progreso, en tiempos pasados iba a contratar trabajadores para servicios comunitarios. El trabajo iba a consistir en levantar encuestas en relación a los problemas que tenía la comunidad. Por ejemplo, aquí la comunidad vive en parqueaderos, vive en ranchos. Nosotros lo que íbamos a hacer era ir a ver cuáles eran sus necesidades escolares, violencia doméstica, problemas de salud. Todos los problemas de la comunidad. Y lo que íbamos a hacer nosotros era por medio del Progresso, canalizarlos a ver dónde los podían ayudar. Nosotros tomábamos el caso. Les dabamos la información, dónde podían asistirlos. Y les tratábamos de poner todos los medios para que esa persona y esa comunidad salieran adelante. Ese era nuestro trabajo, conocer todos los servicios públicos o privados donde estas personas pudieran resolver esos problemas.
Interviewer: ¿Usted conoce la clínica de Mecca?
Male Farmworker: Sí.
Interviewer: ¿En qué forma podemos mejorar la clínica?
Male Farmworker: Pues, aquí en la comunidad de Mecca hay muchas necesidades y grandes. Primero en problemas de emergencia, no hay ninguno. Aquí como es pueblo, no tenemos servicios de paramédicos. Si tenemos una emergencia, la ambulancia llega en 20 minutos, o media hora. 20 minutos muy valiosos para sacar adelante una persona en una emergencia. Problemas de mujeres, de parto... En nuestro caso, cuando mi esposa se iba a aliviar no hubo quien nos diera un ride al hospital. Mi esposa tuvo que irse en el bus. Ir a Indio, tomar otro bus al hospital. En el trayecto de Mecca a Indio, enferma, ya se aliviaba. Llegando el doctor la mando al hospital porque no habían servicios de emergencia.
Interviewer: ¿Hay otras necesidades que usted ve?
Male Farmworker: Bueno. Las necesidades básicas primarias. Como por ejemplo, atención para los niños. Pero yo digo que hay una clínica de salud, pero es tanta la demanda y es muy poco el personal que tienen allí para atender. Pero creo que a nuestra gente se nos creara conciencia que sin salud no podríamos funcionar como padres para trabajar, ni nuestros hijos para estudiar, ni nuestras esposas para sobrellevar el hogar. Nuestros hijos en Mecca tienen problemas como los que se ven en las comunidades de México. Tienen problemas de parásitos intestinales, de piojos en su cabecita. Tienen problemas de anemia. Entonces aquí en este país en zonas como Palm Desert donde hay dinero no existen esos problemas. Aquí nuestra comunidad es pobre y esas necesidades básicas no hay quien se preocupe por ir a nuestros hogares y hacer propaganda para que no existan.
Interviewer: Y en la clínica de Mecca, hay un doctor que habla español, pero nada más. ¿Piensa que necesitan más profesionales que puedan ayudar a la gente? ¿Qué piensa la gente sobre esa clínica?
Male Farmworker: Esta clínica está bien. Esta cumpliendo con su servicio de atender a la gente, pero es muy limitada. Pero realmente su capacidad es limitada. En un día de trabajo normal, el doctor no le da el tiempo al paciente para hacer un buen servicio. Entonces lo que se trata es de pasar pacientes y no dan buen servicio. Bajo experiencia propia, no hay doctores malos. El doctor bueno es aquél que se interesa en tí y te da su tiempo para poder curar tu enfermedad. Pero en este caso como es mucha la demanda, somos muchos con la necesidad. Hay necesidad más grande en diferentes áreas... En mi opinión personal a mi me gustaría que en esta comunidad hubieran servicios básicos con diferentes especialidades de médicos para la atención de nuestra comunidad y nuestros alrededores. Porque es una clínica muy pequeña por nuestra población grande.

FARMWORKERS HOMEBASED IN MECCA, CALIFORNIA

Interviewer: ¿Cuántas personas piensa que viven en Mecca?
Male Farmworker: No sabría decirle. Pero Mecca de hace 8 años al día de hoy, Mecca se ha triplicado su poblacion.
Interviewer: ¿Dicen que sólo hay 1,800 personas pero estoy pensando que más?.
Male Farmworker: La realidad es que Mecca es pueblo de paso para trabajadores emigrantes. Pero ya es gran parte que se ha quedado en Mecca porque Mecca ha crecido al doble, al triple en casas. Y sin embargo, los servicios médicos no existen. Mecca no ha crecido con estos servicios.
Interviewer: Yo entiendo.
Male Farmworker: Solamente la población. No ha crecido al ritmo de las necesidades. Mecca sigue siendo un pueblo con problemas de medicina sencillos pero afecta bastante a nuestra población. Sencillos para el gobierno que tiene los conocimientos que puede sacar adelante. October 26. 1997

MEDICAL CONDITIONS REPORTED

Interviewer: ¿Cuáles son los problemas de salud que tienen los trabajadores del campo?
Female Farmworker: ... Pues todo porque anda uno en la lluvia, en el sol, en el agua trabajando, gripa, dolores. Malo del pecho, pues todo, artritis, todo tiene uno. Las manos, duelen las manos, los huesos. Dolores de espalda, la cintura aquí, luego los pies, las manos, todo el cuerpo duele trabajando en el field. September 20, 1996

Male Farmworker: Los problemas más frecuentes con nosotros son los resfriados por los cambios de temperatura como ya cuando está uno muchos años en el mismo trabajo te empieza a dar problemas de artritis, reumatitis y problemas de asma también que es lo que más nos afecta a los que trabajamos en el campo y regularmente lo que se mira que uno que trabaja con el compañero de trabajo esta mirando que tiene problemas de asma, de bronquios. September 20, 1996

Interviewer: ¿Usted sabe cuáles son los problemas de salud que tienen los trabajadores del campo?
Male Farmworker: Sí, son fuertes, son muy fuertes. La contaminación de la sangre que es el cáncer. Leucemia. Es una de las principales. La otra es bronquios. Problemas sobre los pulmones que respiran. También he oído y he visto como se desmayó la gente en el campo, trabajar en el solaso y se toma su pastilla que era una pastilla de sal para seguir aguantando. ... March 4, 1997

Female Farmworker: Problema de salud puede ser aquí, dolor de la cintura, espalda, cuando hay mucho sol, a veces se siente uno mareado, dolor de cabeza por el sol, te quema la cara. Hay gente que no nos acostumbramos a ponernos los pañuelos que usan la mayoría de aquí. Yo, a veces no puedo respirar con esto aquí porque para la uva tiene que estar completamente tapada porque la azufre de la uva que le ponen y el sol. Por eso se tapa uno, y si no se tapa, sale quemada del sol. Es otra causa. Si va de los surcos, a veces se resbala uno y se lastima un pie, un resbalón. Con un resbalón se puede uno falciar el pie.
Interviewer: ¿Tiene usted problemas de la salud porque estás trabajando en el campo?
Female Farmworker: A veces a uno se le irrita. Por ejemplo como ahorita que estoy en cepillo de la uva en deshoje, en la azufre, como no tengo lentes, no nos dan lentes, nos cae azufre a los ojos y los ojos irritados no puede uno ni ver. Y la uva cuando cepillamos, nos cae a uno en los ojos y no puede uno ni ver. Lastima la garganta también porque el polvito ese nos cae a la garganta, a la nariz. Traigo también la nariz irritada por la misma azufre. March 11, 1997

Interviewer: ¿Cuáles son los problemas de salud que tienen los trabajadores del campo que usted ve?
Female Farmworker: Pues ahorita lo que más se ha visto es de los insecticidas, alergias.
Interviewer: Explica más.
Female Farmworker: O sea, problema de los insecticidas es consecuencia de que le da a uno dolores de cabeza, dolores de estómago o alergias que le salen a uno en el cuerpo, granos, ronchas, a veces a uno hasta la vista se le nubla. Es lo que más le afecta a uno que trabaja en el campo.
Interviewer: ¿Y los hijos de los trabajadores?
Female Farmworker: He visto en algunos que yo tengo años trabajando en la compañía que trabajo en agricultura, que muchos niños salen a veces defectuosos.

Interviewer: ¿Cómo?
Female Farmworker: ¿Cómo?, ah! no sé cómo les llaman aquí, pero nosotros les llamamos, como tontitos. Es problema de eso, o que nacen con algún problema mental, algún problema de la vista, de los oídos casi no oyen, en el habla.
Interviewer: ¿Qué dicen la gente cuando esto pasa?
Female Farmworker: Pues, muchos le echan la culpa a eso, otros dicen que enfermedades, no le sabría decir. Pero yo que trabajo en el campo, yo si he notado cuando andan echando insecticidas que yo ando trabajando en el field y a veces andan regando el insecticida en fields cercanos donde anda uno trabajando. Le duele a uno la cabeza, incluso el año pasado a mi eso me pasó y me marié andaban regando un field y nosotros andábamos allí cercas y luego, luego note luego, luego la reacción cuando yo anduve bien trabajando y de repente me dió un dolor de cabeza y un dolor y un olor bien feo en la nariz.
Interviewer: ¿Cómo se llama esa química?
Female Farmworker: No sé, porque como el avión andaba retirado no sé cómo se llamará.
September 19, 1996

Interviewer: ¿Cuáles son los problemas de salud que tienen los trabajadores del campo, qué sabes?
Female Farmworker: Yo sé, casi por lo regular las personas que yo he oído que han tenido problemas es por los fertilizantes. Inclusive, yo tuve una amiga que se murió. Ella trabajaba mucho con fertilizantes y le dio un problema pulmonar o sea ella tosía mucho, tosía mucho. Mucho tiempo estuvo bajo tratamiento, dejo de trabajar y la mandaban a Phoenix, la mandaban a muchas partes, le hacían muchas cosas y no pudieron ayudarla. Ella trabajó mucho en la uva. Y al último eso fue lo que le dijeron, que a ella le habían afectado mucho los fertilizantes. Ella casi se ahogaba, como asma y ella estaba embarazada y ella se alivió, y ahora miramos su niña tiene 5 años y su niña tiene la misma tos que tenía su mamá y tiene la misma, que tose, tose, tose hasta que se ahoga, pero es una tos muy muy fea.
Interviewer: ¿Tal vez es tuberculosis?
Female Farmworker: No, le hicieron eso todo. Es nomás de los pulmones, la química que usaron, en ese tiempo le afecto mucho su embarazo a ella y los pulmones como que se los congestionó demasiado.
Interviewer: O.K. ¿Cómo se llama esta química?
Female Farmworker: No sé... Y porque eso son de como unos 7 años para atrás y según eso, han renovado los químicos que echan, pero es lo mismo de todos modos, nomás renovarán algunas cosas pero todo el tiempo va a ser lo mismo porque las químicas no las van a dejar de usar. Y esta vez que yo vaya, voy a investigar porque esto fue en Arizona, no hay uva en Arizona, pero de allí es la señora entonces la hija vive allí y tal vez ella sepa. September 19, 1996

Male Farmworker: Luego las químicas.
Female Farmworker: Oh y granos también le salen a uno.
Interviewer: ¿Cómo se llama esta química?
Male Farmworker: No sé. Ellos en la lechuga, la esprayan y queda un polvito. Como polvo y dan infecciones fuertes en los ojos, en la vista. Se te hacen granos en las manos, como alergia, mucho granito. Te quieres cortar el cuero, la piel.
Female Farmworker: Da tanta comezón... En Huron, Yo noto como que en Huron, usan una química más fuerte para eso de la planta. Nosotros tenemos un amigo que agarraba hasta navaja, cuchillo para rascarse los granos de tanta comezón que traía y asi mira bien alérgico. Ya fue al doctor y todo y dicen que es alergia y no se la pueden curar. Oh sea el se metía a bañar como 3 veces en la noche porque era una comezón insoportabe, rascarse hasta sangrarse. Y pomadas, y pomadas y ninguna le hace provecho. A mí me ha salido alergia pero por los guantes que nos ponemos y todo el polvo pero se me quita nomás queda como mancha pero no es muy....
Interviewer: ¿Tiene una mancha ahora?
Female Farmworker: Ahora, o sea que se me quita, o sea son muy leves las manchas, no es muy notorio. Ahora no tengo. O sea se mancha la piel porque son muchos granitos y da mucha comezón. No más que en esa area de Huron, yo me pongo mal. September 19, 1996

MEDICAL CONCERNS UNIQUE TO MIGRANT FARMWORKER HOUSEHOLDS

Interviewer: ¿Cuáles son los problemas de salud que tienen los trabajadores del campo?
Male Farmworker: ¿Problemas de salud? Por ejemplo la higiene que está muy mal.
Female Farmworker: Es un cochinero las casitas que nos dan.
Male Farmworker: Y los baños y todo eso.
Female Farmworker: Los baños están afuera.
Interviewer: ¿Los comparten?
Male Farmworker: Todo el mundo. O sea, que dan infecciones allí. Yo hace un año agarré una infección en un pie, que por cierto hasta en México me la controlaron.
Female Farmworker: Es que es un cochinero.
Male Farmworker: Pero sigo trabajando allí.
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Interviewer: ¿Y cree que los trabajadores del campo que viajan tienen diferentes problemas que los trabajadores que se quedan en el mismo lugar?
Female Farmworker: Sí, porque el migrante tiene más probabilidad de enfermarse porque como viajan por un lado, viajan para otro lado es más problema para ellos. Los que se quedan no porque tienen su casa, dejan de trabajar, piden su desempleo, tienen sus estampillas comen y están a gusto. Por esos 6 meses no van a enfermarse de gripas y de otras cosas. Si les da una calentura o una muela o algo, están en su casa a gusto. Nosotros no estamos en el solaso trabajando. September 24, 1996

Interviewer: ¿Y bueno, cuando ustedes estan emigrando por el campo sabe dónde están las clínicas de salud en la comunidad?
Female Farmworker: No
Interviewer: ¿Y sabe dónde esta la sala de emergencia cuando está trabajando arriba? ¿no?
Female Farmworker: No, solo vamos a trabajar y ya.
Interviewer: ¿Y sabe dónde puede usted comprar las medicinas?
Female Farmworker: No, pues yo pienso que hay nomás en la tienda buscando la farmacia por allí.
Interviewer: ¿Y cuando esta viviendo arriba tiene usted problemas con transportación cuando un miembro de la familia necesita ir al doctor?
Female Farmworker: Sí, porque si.
Interviewer: ¿Por qué?
Female Farmworker: Porque nomás tenemos un carro y es el que llevamos al trabajo. Si ellas tienen que ir al doctor, pues nosotros dejamos medio tiempo el trabajo para llevarlas a ellas. ... March 24, 1997

MEDICAL CONCERNS UNIQUE TO NON-MIGRANT FARMWORKER HOUSEHOLDS

Interviewer: ¿Qué tipos de problemas de salud tienen usted y su niño aquí en Mecca?
Female Farmworker: Bueno, un problema, que pudiera resultar en problema de salud es aquí estos departamentos...
Interviewer: ¿En su trailer?
Female Farmworker: En la trailer es, ahorita la alfombra. Tenemos una fuga donde lava uno los trastes y hay humedad, entonces esa humedad a veces nos provoca problemas respiratorios por esa misma humedad. El calor se encierra demasiado el calor, demasiado el frio. Es esos detalles nada más. Y problemas del gas. A veces hay fuguitas allí.
Interviewer: ¿Fugas?
Female Farmworker: Por ejemplo aquí del gas que no esté bien cerrado y se salga el gas.
Interviewer: ¿Pues usted dice que hay problemas de salud en los departamentos?...
Female Farmworker: ...La pintura del departamento tiene plomo. ... Y otra situación que le quería comentar, por ejemplo del zancudo. Tuvimos problemas de meningitis.
Interviewer: ¿De veras?
Female Farmworker: No supimos porque, no supimos como, pero la niña tenía algunos piquetes de moscos. La niña chiquita tenía como unos 3 meses y tuvo meningitis. Y nos dijeron que toda la familia tenía que ir a hacer un examen. Pero tuvimos que pagar. Unos tenían Medi-Cal. Mi niño no tenía Medi-Cal completo, yo tampoco. March 11, 1997

Interviewer: Ahora podemos hablar un poquito sobre los Tés. Tenemos aquí dos señoras. Y tengo mis tés aquí en la pared y ellos los escojen. they chose them y vamos a platicar sobre cada uno. Por favor señoras, enseñenme. ¿Rosa de Castilla?
*Female Farmworker 1:*La **Rosa de Castilla** se usa como una infusión o té. Para un bebé chiquito en tetera como laxante.**Arnica** es una de las maravillas que la naturaleza ha creado. Puede cocerla y es excelente por experiencia propia como un antibiótico en una herida.
Interviewer: ¿Un antibiótico como en qué?
Female Farmworker 1: Infecciones de la piel, en una herida. Se lava la herida como 3 veces al día con agua hervida de arnica. Mejor que cualquier medicina que de un médico.
Interviewer: Algún día voy a traer este a tu casa y enseñame. ¿Qué más?
*Female Farmworker 1:***Sauco**. La flor de Sauco es maravillosa para la tos como té. Se puede cocer una cucharadita o dos, unas 4 hojas de Eucalipto y Manzanilla. Entonces esto también se toma unas 3 veces por día por unos días hasta que la flema y la tos disminuya endulzado con miel.
Interviewer: Necesitamos saber cómo la gente las usan, porque tenemos que seguir con estas tradiciones. Muchos de los jóvenes, como yo, no saben.
*Female Farmworker 1:***Epazote** es también maravilloso para desparasitar. Se puede tomar en té y también se puede usar como especie para la comida. Para el pozole, para chilaquiles y da un sabor muy agradable, pero es principalmente para los parásitos intestinales.
Interviewer: ¿Para cuántos días?
Female Farmworker 1: Uso diario no afecta. Es bueno. La **Manzanilla** es para el dolor de estómago también para la tos. Hasta para pintar el pelo. Coces Manzanilla y te la pones en el pelo, y te haces guerita.
Interviewer: ¿Qué más?
Female Farmworker 1: **Ruda**. Otra de las yerbas maravillosas de la arbolaria Mexicana. Puedes poner hierba adentro de una botella de alcohol. Cuando el agua se pone verde, puedes mojar un algodón y ponerse a veces cuando el ojo tiene legaña como normalmente se dice. A veces no es por infección, a veces es por golpe de aire y si tú te limpias los ojos sin que caiga el alcohol adentro con algodón mojado con esto se limpia, es maravilloso. También puede ser tomada cuando duele la cabeza. Ruda con chocolate y un huevo, te la tomas y ayuda a dormir muy bien. Cuando a veces las muchachas como Kathy que estudian y que no pueden conciliar el sueño, un té de Ruda con chocolate y leche, es suficiente para poder dormir. Y quita el dolor de cabeza.
Interviewer: ¿Qué más?
Female Farmworker 1: El **Cidrón** es también para dolor de estómago como té. Puede ser su uso diario, continuo como si fuera café, pero mucho más sano. La **Mejorana** es otra cosa. Es para la comida. Caldillo, menudo, albondigas. Pues para la cocina. Como medicina yo no la uso. La **Albahaca o Basil** es para el estómago. También ayuda al estómago pero también para la cocina. Puede usarse para el spaghetti. El té de **Limón** se dice que es bueno para los nervios. Una tazita en la noche y es conciliador del sueño.
Female Farmworker 2: De todas estas yerbas que se han hablado son muy buenas. Y las he usado. Por experiencia lo digo. Mayormente la **Ruda**. Se agarra una hojita verde y se la talla uno si le duele la cabeza o si tiene un dolor de aire, que sepa uno que le dio aire. Es muy buena. Todas éstas que hemos hablado hacen maravillas. Muy buenas.
Interviewer: ¿Usted sabe de un té para el dolor de los oídos?
Female Farmworker 2: La Ruda también. Se puede poner un algodoncito en el oído y luego ponerse unas hojitas de ruda. Ruda fresca.
Interviewer: ¿Hay tés para la gente que está embarazada?
Female Farmworker 2: Bueno, eso también se tiene que preguntar La **Manzanilla** se dice que cuando una mujer está a punto de dar a luz, si se toma uno tés de Mazanilla cuando ya los dolores han empezado, todo va mejor. Puede ser más rápido el nacimiento del bebé. January 1998

Female Farmworker: El sobador, el sobador, ése que no falte, y ahora yo creo que no me va a faltar nunca. Cada ocho días yo creo que voy a ir a verlo. Para no tuyirme porque no creas que te estruja, no más te hace esto así. Te agarra así de los pies, así te va haciendo y luego trac te truena. El no más te busca los nervios y acá te los truenan. A veces que me duele la rodilla, te busca esto así y acá te los truena. De acá te los truena en la frente.
Interviewer: ¿Sabe cómo se llama?

TRADITIONAL MEDICAL PRACTICES

Female Farmworker: XXX se llama el señor XXX.Es una cosa maravillosa, te deja tan a gusto. Como yo que me duele tanto el cuadril que a veces me arde como chile, que me duele mucho mucho, lo único que veo yo que me soba aquí y me truena los nervios aquí. Pero ya después que te truena todo, te hace así con las manos y se oye trac, trac,trac tu cabeza. Y así no más te hace. Las anjinas te las truena y no te vuelven a salir. Bien interesante lo de ese señor, que yo me quedé admirada, admirada porque yo todos los días me paralizaba, pero yo todos los santos días, paralizada, más al principio. September 19, 1996

DENIED MEDICAL ATTENTION

Interviewer: ¿Y en alguna ocasión le han negado atención médica a usted o a un miembro de su familia?
Female Farmworker: A mi hijo.
Interviewer: ¿Qué pasó?
*Female Farmworker:*El se lastimó la mano y no lo quisieron atender en Yuma. El ya estaba, ya lo iban a operar, ya estaba el anestecista y todo y el doctor preguntó si tenía aseguranza y cuando dijo que no tenía aseguranza o que si había agarrado el Medi-Cal, y él dijo que no había ido, canceló de operar.
*Male Farmworker:*No lo quiso operar.
Interviewer: ¿Entonces qué pasó?
*Male Farmworker:*No lo pudo operar ese día y estuvo yendo más tiempo y agarrando todos los papeles hasta que agarró todo, lo operaron. Pero tuvo que esperar como casi un mes.
Interviewer: ¿Qué tipo de lugar le negó asistencia médica? ¿Una clínica?
Female Farmworker: No, el hospital de Yuma. Pues, no el hospital, el doctor que lo estaba atendiendo.
Interviewer: ¿Este doctor es privado?
Female Farmworker: No sé. September 20, 1996

REALIZED ACCESS AND PUBLIC INSURANCE

Interviewer: ¿Hubo un tiempo en su vida donde no tuvo seguro?
Female Farmworker: Sí, cuando no trabajo, no tengo aseguranza.
Interviewer: ¿Y qué pasa?
Female Farmworker: Aplico para la Medi-Cal.
Interviewer: ¿Es fácil recibir Medi-Cal?
Female Farmworker: Es un poco difícil, se nos pone a nosotros porque como vinimos de allá del área de Yuma, tenemos que meter papeles de todo, cada mes, cada mes. Como un mes si nos dan otro mes no nos dan. Como ahora yo tengo el problema, que mi esposo se tiene que estar atendiendo porque está enfermo entonces me negaron la Medi-Cal para él ahora este mes. Me la negaron que porque la compañía de él le dio aseguranza, pero no cubre todo la aseguranza. Entonces yo apliqué otra vez para la Medi-Cal para él porque él se tiene que estar atendiendo y me le negaron la Medi-Cal a él y a mí también me la negaron no más mis hijos son los que si podían calificar para la Medi-Cal. Tiene una enfermedad que le llaman la úlcera y le tienen que estar chequeando cada mes, cada dos meses, entonces como la compañía le dio aseguranza pero la aseguranza no le cubre todo. O sea la aseguranza te cubre un 80%, lo demás no te lo cubre. Como a él, ahorita tiene una cita para el 26 de este Setiembre, tiene una cita donde le van a meter una cámara para adentro entonces, yo le expliqué a mi trabajadora social de eso, entonces ella me dijo que de todos modos, no le iban a dar Medi-Cal. Yo quería que a ver si le daban Medi-Cal por lo que la aseguranza no cubra la Medi-Cal pueda cubrir y me le negaron la Medi-Cal. Y el es ciudadano, aquí ha trabajado, aquí ha vivido, y le negaron su Medi-Cal... September 19, 1996

Interviewer: Tiene Medi-Cal o tal vez no?.. Tal vez que vas a hacer?
Female Farmworker: Pues el problema que va haber cambio de la Medi-Cal que tenemos regular, la queremos así como está.
Interviewer: ... ¿Usted dice que Medi-Cal va a cambiar?
Female Farmworker: Sí
Interviewer: ¿Por qué?

Female Farmworker: Pues nos mandaron decir que ya no va haber Medi-Cal como el que tenemos. Que ahora va a ser ProCare y la mía y otra más. Pues nosotros tememos de eso porque yo una vez agarré el Pro Care y no nos gustó porque no cubría doctores, no cubrían medicinas, y eso está pasando.
Interviewer: ¿Entonces éste es un HMO? ...
Female Farmworker: Sí, o sea, le tememos que nos cambien por otras Medi-Cales como le digo esa ProCare y eso tememos porque no nos cubre doctores que vemos.
Interviewer: ¿Y este nuevo Medi-Cal va a cubrir para servicios en este valle, o tienes que ir hasta Riverside, u otros lugares?
Female Farmworker: Lo que dicen ellos, que si no lo mandamos nosotros el paqete, que ellos nos van a poner los doctores que ellos quieren. Pero nosotros queremos nuestros doctores. Como una apariencia, ellos quieren no más un doctor. Si yo escojo la de la clínica aquí en Mecca, y si está cerrada, como vamos a ir con otro doctor si esta cerrada. Por eso es bueno 2 doctores pero no, dicen que no más 1 tenemos que tener ... March 1997

Interviewer: ... esta señora no tiene seguro ahora, y ella va a platicarme como ella va a tener su seguro.
Female Farmworker: Tengo que trabajar primero un mes para poder calificar. Pero ya solamente para Mexicali, porque aquí tengo que pagar primero $100 dólares y ya después me cubre.
K: ¿Y éste puede cubrir todos sus niños.
Female Farmworker: Sí.
Interviewer: ¿Y por qué no puedes calificar para Medi-Cal? ¿... porque ustedes son de bajos ingresos?.
Female Farmworker: Sí, somos de bajos ingresos pero no sé según que ya es ley nueva que entró.
Interviewer: ¿Tienes mica pero qué pasa con el Medi-Cal?
Female Farmworker: Pues, no sé, nomás me dijeron que no.
Interviewer: ¿Ellos dicen que hay nueva ley?.
Female Farmworker: Que hay una nueva ley.
Interviewer: ¿Qué dicen que ...?
Female Farmworker: Que tiene que calificar para eso. Pues no le entendí bien en eso, estuve llenando muchos papeles también que le pidieron a mi esposo en la compañía donde estuvo trabajando. Se los llevé como 3 veces a mi trabajadora y pues me dijo que no estaban bien llenos. Se los volví a llenar y los volví a llevar. Y pues ella entonces me dijo que no, que no calificaba. Me dijo que no, que no calificaba y ya no seguí yendo, porque no sé manejar y para estar pidiendo raite, se me ponía.
Interviewer: Sí, es muy importante que me digas eso.
Female Farmworker: Mi niña, la de 4 años porque ella es la que seguido se me enferma de eso de la infección de garganta y luego se le pasa al oído y le sale como pus y le entra calentura
Interviewer: ¿Sí?
Female Farmworker: Y se me pone muy grave y pues le hablé a mi trabajadora y me dijo, llévela de emergencia al hospital y ya después me dijo que no me cubría. Que tal si la hubiera llevado al hospital de emergencia hubiera tenido que pagar todo lo que me hubieran cobrado de todo allí en el hospital.
Interviewer: ¿Qué pasa, usted la lleva a ella a México, o cómo?
Female Farmworker: Pues alguien que va allá a Mexicali voy yo con ellas para que me le den medicina allá en Mexicali porque sale más barato. March 22, 1997

Female Farmworker: Sí, fui a que operaran a mi niña de las anginas a Mexicali porque la aseguranza allá cubre el 100% y aquí nada más el 80%. Allá no tengo que pagar nada aunque tengo la Medi-Cal pues tengo que meter las 2 cosas al mismo tiempo y es complicado porque a veces le siguen mandando a uno cobros y cobros y cobros y se hace difícil cobrarle a una y pues no puede pagar la otra porque como están las 2 es difícil.
Interviewer: ¿Prefiere tener usted solamente Medi-Cal o prefiere tener solamente TransWestern?
Female Farmworker: Prefiero tener, si se pudiera tener Medi-Cal estaría bien porque cuando tengo el TransWestern yo dejo de trabajar y se me termina la aseguranza ya no tengo nada.
Interviewer: ¿Entonces, en un año, hay tiempos en un año, hay meses en un año donde usted solamente tiene puro Medi-Cal?

REALIZED ACCESS AND PUBLIC INSURANCE

Female Farmworker: Sí, hay meses del año que nomás tengo Medi-Cal.
Interviewer: ¿Qué meses? ¿en el invierno?
Female Farmworker: No, es cuando se acaba la temporada de nosotros en el empaque que sería Junio, Agosto, y ya para Setiembre.
Interviewer: ¿Entonces su niño necesitaba tener esta operación, en qué mes? ¿En qué mes el año pasado?
Female Farmworker: Tuvo la operación como en Marzo o Abril.
Interviewer: Okay. Ya
Female Farmworker: A mí me operaron de la nariz.
Interviewer: ¿Otra operación, en México?.
Female Farmworker: En México porque tenía un tabique desviado.
Interviewer: ¿El qué?
Female Farmworker: El tabique desviado. No sé cómo se diga.
.... Tenía el tabique desviado y fue el mismo problema y fue en Mayo.
Interviewer: ¿Entonces no quieres usar tu Medi-Cal o TransWestern porque es más difícil?.
Female Farmworker: Sí, se nos hace más difícil. Porque usamos las dos y están llegando los cobros llegando y llegando. Nada más allá metemos la aseguranza y allá se cubre todo. Nomás nos mandan un papel de lo que pago la aseguranza ya esta cubierto todo. April 7, 1997

REALIZED ACCESS ISSUES AND EMPLOYEE-BASED INSURANCE

Interviewer: Pues, tú me dijistes algo sobre que tienes que trabajar algunas horas antes de que uno puede usar su seguro. Por favor explícame este proceso.
Female Farmworker: Tenemos que hacer unas horas. No se ahorita cuántas son, pero tenemos que tener algunas horas para poder calificar para la aseguranza.
Interviewer: Entonces, ¿ahora usted califica para este mes?
Female Farmworker: Para este mes nada más que ya se va a terminar. Pero como nos pararon de trabajar, tengo que empezar otra vez y tengo que hacer las horas para poder tener aseguranza...
Interviewer: Después de esto, ¿va usted a pedir Medi-Cal para sus hijos o para usted?
Female Farmworker: Yo casi siempre lo he tenido el Medi-Cal. Ahorita me lo quitaron no sé por qué. Es que yo tuve problemas con mi trabajadora, que no me mandaba reportes y no se los estaba regresando pero no había quitado de allí ... February 24, 1997

Interviewer: ¿Cómo se llama su aseguranza?
Male Farmworker: Western .... no sé para que le digo mentiras. A nosotros los mayordomos así como de 5 mil dólares nos cubre el 100% después como ahora que mi esposa tuvo las cuatas tuvo muchos problemas. Yo creo que salió arriba de 100 mil dólares y yo no tuve que pagar ni un cinco, nada tuve que pagar yo. Y los trabajadores como le digo como si llevo a la niña aquí tengo un deducible de 500 dólares. Tengo que pagar primero los primeros 500 dólares para como una enfermedad de la niña o algo que son leves que salió en 30 dólares, entonces hasta que no se acumule en el año 500 dólares o que pase arriba de 5000 dólares entonces, y es lo mismo en los trabajadores , pero a mí me cubre el 100% y a los trabajadores le cubre el 80% aunque hayan pagado los 500 dólares o sea por una persona son 200 dólares, si es un hombre solo o una mujer sola tiene que pagar los 200 dólares de su deducible ya que paguen eso le empiezan a pagar el 80% de lo que este gastando. September 13, 1996

Interviewer: ¿Cuándo fue la última vez que solicitó atención dental para usted o para una de sus hijas?
Female Farmworker: Yo compré una aseguranza, o sea no la compre, me ofrecieron una aseguranza aquí en mi trabajo que me estaban rebajando del cheque por eso digo que compre la aseguranza, porque no se la estan dando a uno. Me están rebajando cada dos semanas que me pagan, del cheque, me están quitando como $25 por cada dos semanas.
Interviewer: ¿Sabe usted cómo se llama esa aseguranza que le ofrecen?
Female Farmworker: No sé, aquí tengo la tarjetita.
Interviewer: ¿La aseguranza no cubre nada de medicina, sólo para el cuidado de los dientes?

REALIZED ACCESS ISSUES AND EMPLOYEE-BASED INSURANCE

Female Farmworker: Yo creo que nomás eso, no se le hicieron, de una carie que tenía le hicieron unos hoyos, no le taparon uno, le cayó infección.
Interviewer: Del trabajo, ¿su seguro sirve para los dientes pero no para su salud?.
Female Farmworker: No, bueno sí, sí me ofrecieron para la salud pero si las compraba las dos me salía mucho más caro, casi el doble.
Interviewer: ¿Por eso ahora tiene seguro sólo para sus dientes?.
Female Farmworker: O sea que los de los dientes salía más barato. El de la salud salía más caro, muchísimo más caro.
Interviewer: ¿Dice que no le taparon las caries?.
Female Farmworker: No le taparon, acá le hicieron un hoyo atrás, y dice mi hija, mami me dejaron un hoyo, no me lo taparon. Pero ella se fue a Arizona y hasta allá se dió cuenta. September 19, 1996

REALIZED ACCESS AND THE UNINSURED

Interviewer: ¿Qué le ha ocurrido por falta de aseguranza médica? Usted me dice que problemas con Medi-Cal y los dientes.
Female Farmworker: Perdí dos muelas o dientes por falta de la Medi-Cal porque me la quitaron. No estaba trabajando y no tenía pruebas de ingresos. Y también mi niña necesitaba mucho ir al dentista. También se me puso muy mala de los dientes y como no tengo dinero ni tenía aseguranza ni nada, yo perdí los dientes, las dos muelas. Y mi hija sufrió mucho también por esa causa, la chiquita de 6 años.
Interviewer: ¿Le gusta usted Medi-Cal?
Female Farmworker: Sí. El problema que yo he tenido es que me la han quitado 2 veces porque como yo dejo de trabajar y mi esposo estaba deshabilitado y no le estaban dando dinero, entonces me la quitaron cuando yo más la necesitaba. Porque no tenía las pruebas. Piden los talones.
Interviewer: ¿Pero por qué no va a un desempleo?
Female Farmworker: Porque no me dan desempleo. En el distrito no dan desempleo. Entonces yo llevé los talones del field, los talones de los cheques y no me los quisieron aceptar. No tenía dinero, no tenía trabajo.
Interviewer: ¿Y usted no podía ir a la oficina de desempleo?.
Female Farmworker: Piden prueba de ingresos, de trabajo, talones de cheque. Yo los llevé de el mes que me lo pidieron pero no me los quisieron aceptar porque dijeron que eran temporal. Y lleve los talones de 3 diferentes compañías donde yo busqué trabajo por lo mismo para que me dieran Medi-Cal y me la quitaron. Y yo ocupaba mucho. Para ir al doctor también porque estaba sufriendo de dolores aquí en los ovarios y no pude ir al doctor. Hasta ahora que me dieron Medi-Cal fui a que me hicieran un sonograma para ver que es lo que tengo. February 18, 1998