



JSRI

Publications

**Access to Medical Insurance Among
Migrating and Non-Migrating
Farmworkers: A Case Study from
Rural California**

by Kathryn Azevedo
Post Doctoral Fellow, Stanford University Medical Center

Research Report No. 06
July 2001

The Midwest's premier Hispanic center undertaking research on issues of relevance to the Hispanic community in the social sciences and economic and community development. JSRI is a unit of the College of Social Science and is affiliated with the College of Agriculture and Natural Resources at Michigan State University.

Access to Medical Insurance Among Migrating and Non-Migrating Farmworkers: A Case Study from Rural California

by Kathryn Azevedo

Post Doctoral Fellow, Stanford University Medical Center

Research Report No. 06

July 2001

Acknowledgements:

The author wishes to acknowledge the incredible support of her dissertation committee - Dr. Arthur Rubel, Dr. Francesca Cancian, and Dr. Leo Chavez. The following provided financial support: the California Program on Access to Care (CPAC), the University of California Institute for Mexico and the US (UCMEXUS), UCI Latinos in a Global Society, UCI School of Social Sciences Summer Research Grant, and the University of California President's Dissertation Fellowship.

All photographs used in this publication are provided by the author, Kathryn Azevedo.

About the Author: *Kathryn Azevedo, Ph.D., ATRIC*

Kathryn Azevedo is currently a post-doctoral fellow conducting clinical research at Stanford University Medical Center. As a Senior Research Associate of the Tomás Rivera Policy Institute, Dr. Kathryn Azevedo has examined the issue of Latino under-enrollment in California public insurance programs and ways to increase enrollment of eligible non-participating Latinos, a study funded by The California Endowment. She received her doctorate at the University of California, Irvine in Social Relations with an emphasis in medical social science. She researches community participation in health, disability issues, farmworker health, and access to medical services among California's rural poor. As a researcher, health educator, and rural community health worker, she has worked with people experiencing arthritis, lupus, diabetes, post-stroke, spinal cord injury, AIDS, autism, cerebral palsy, and tuberculosis in both Mexico and in the United States. She has worked for the California Institute for Rural Studies, the Centers for Disease Control, numerous hospitals, and the NASA/AMES Research Center. Kathryn Azevedo is also active in several professional organizations and is also a pediatric aquatic specialist with Aquatic Therapy and Rehabilitation Industry Certification.

SUGGESTED CITATION

Azevedo, Kathryn, Ph.D. "Access to Medical Insurance Among Migrating and Non-Migrating Farmworkers: A Case Study from Rural California," *JSRI Research Report #06*, The Julian Samora Research Institute, Michigan State University, East Lansing, Michigan, 2001.

The **Julian Samora Research Institute** is committed to the generation, transmission, and application of knowledge to serve the needs of Latino communities in the Midwest. To this end, it has organized a number of publication initiatives to facilitate the timely dissemination of current research and information relevant to Latinos.

- *Research Reports*: **JSRI**'s flagship publications for scholars who want a quality publication with more detail than usually allowed in mainstream journals. These are produced in-house. Research Reports are selected for their significant contribution to the knowledge base of Latinos.
- *Working Papers*: for scholars who want to share their preliminary findings and obtain feedback from others in Latino studies.
- *Statistical Briefs/CIFRAS*: for the Institute's dissemination of "facts and figures" on Latino issues and conditions. Also designed to address policy questions and to highlight important topics.
- *Occasional Papers*: for the dissemination of speeches, papers, and practices of value to the Latino community which are not necessarily based on a research project. Examples include historical accounts of people or events, "oral histories," motivational talks, poetry, speeches, technical reports, and related presentations.

Access to Medical Insurance Among Migrating and Non-Migrating Farmworkers: A Case Study from Rural California

Table of Contents

Introduction	1
Migrant Streams	1
Medical Services for Agricultural Workers	2
Social Science and Healthcare Access	3
Field Sites	6
Demographics	10
Employment Characteristics	15
Farmworker Lifestyle, Work, and Health	17
Living and Working in Northern California	17
Living and Working in Southern California	20
Medical Conditions Reported	23
Access to Medical Services	25
Potential Access to Medical Services	26
Public, Private, and Charity Health Programs	27
Findings	33
Realized Access to Medical Services	35
Realized Access and Public Insurance	37
Realized Access and Employee-Based Insurance	40
Realized Access and Services in Mexico	41
Realized Access and the Uninsured	42
Examining Realized Access	42
Summary	43
The Political Economy of Healthcare Access	44
Summary and Conclusions	45
Policy Research Findings	46
Recommendations	47
Conclusions	48
References	49
Appendices	55

Access to Medical Insurance Among Migrating and Non-migrating Farmworkers: A Case Study from Rural California

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; Villarejo, 2000; Wells, 1996). 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 the perspective of a political economy of health, this research examines healthcare 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 healthcare 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 healthcare 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.

Migrant Streams

Estimates on the number of agricultural workers throughout the United States range from 1 million to 5 million. The most commonly cited figure estimates the total number of migrant and non-migrating farmworkers and their dependents to be approximately 4.2 million nationwide (Quandt et.al., 1998; Dever, 1993). Growers in 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 around 700,233 persons in California (Larson, 1993).

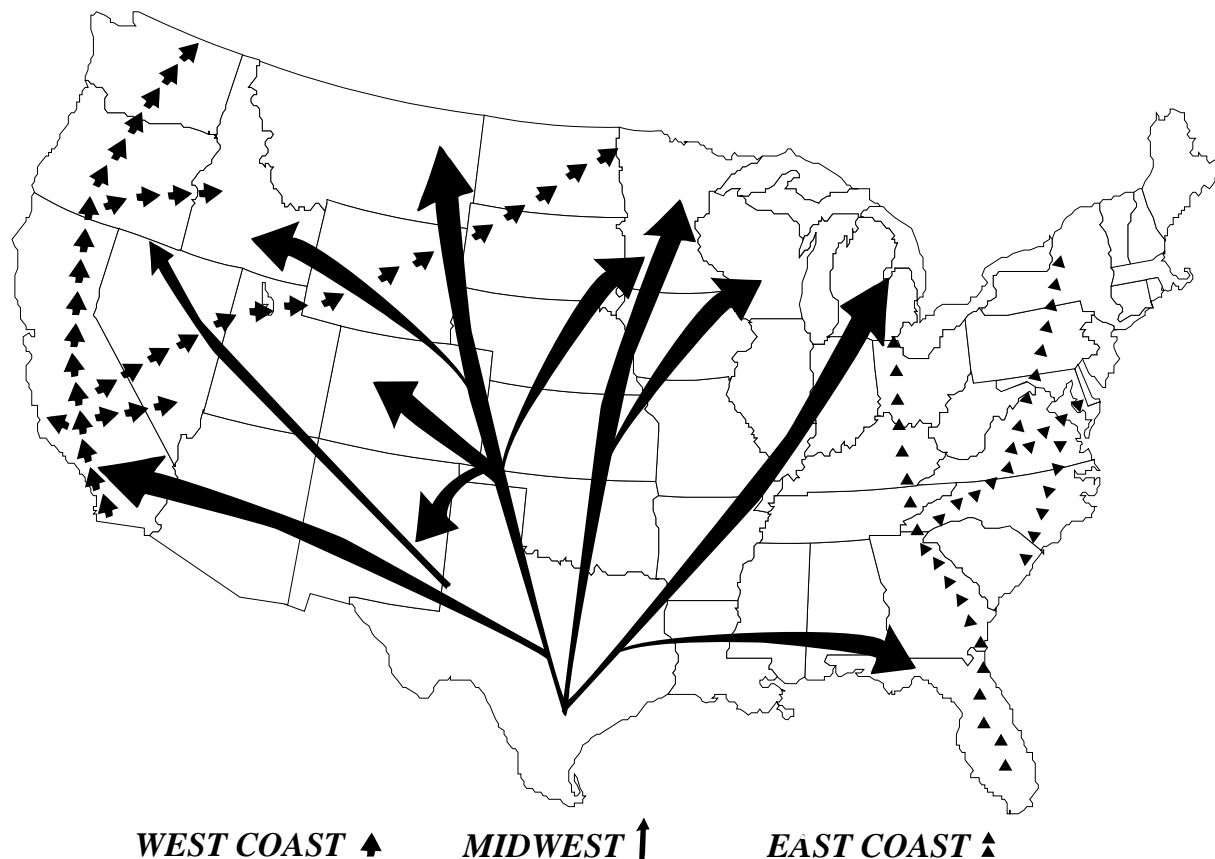
The migratory patterns of agricultural workers are referred to in the literature as "streams." Three major streams are described – the East Coast, Midwest, and West Coast streams. Characteristic of each stream is a "homebase" downstream, where these laborers reside and work when they are not traveling (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 (Figure 1).

The homebase area where this research project was conducted is located in a desert portion of the Southwest bounded on the west by the Coachella Valley and, on the east, by Yuma, Ariz. Many low-income farmworker families now live here because of the lower costs of living, the close proximity to Mexico, and 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 are distinguishable from non-migrating, or "seasonal," 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 each workday.

In light of the morbidity seen among farmworker families, a nationwide system of primary healthcare clinics began operation in the 1960's 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

Figure 1. The Major Migrant Streams



Source: National Migrant Project, Inc. (NMRP) NMRP renamed to National Center for Farmworker Health, Inc.

and continues to expand in the 1990's. The following section discusses this important program.

Medical Services for Agricultural Workers

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 healthcare 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. (Migrant Health Centers Referral Directory, 1998). See Figure 2 for the nationwide distribution of CMHC clinics.

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% of the farmworker population (Benavides-Vaello et al.,1994; Wilk; and Rust,1998). Despite the introduction of the Migrant Health program in the United States and political commitments to providing healthcare 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 (Migrant Health Centers Referral Directory, 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; both research sites are served by primary healthcare clinics.

Figure 2. Health Centers Serving Migrant and Seasonal Farmworkers



Source: National Center for Farmworker Health, Inc., Austin, Texas, November 1997

In the Southern California homebase location in Mecca, Clínicas de Salud del Pueblo, based in Brawley, 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 of the health center. 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.

In both field sites chosen for this research project, farmworker households lived in close geographic proximity to a primary healthcare clinic. Both clinics described above have the capacity to refer patients to other medical sites for more specialized care. 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, the geographic location of the medical clinic was less likely to function as an access barrier and, thus, allowed for closer examination of the policy-related issues. Figure 3 illustrates CMHC centers in California.

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

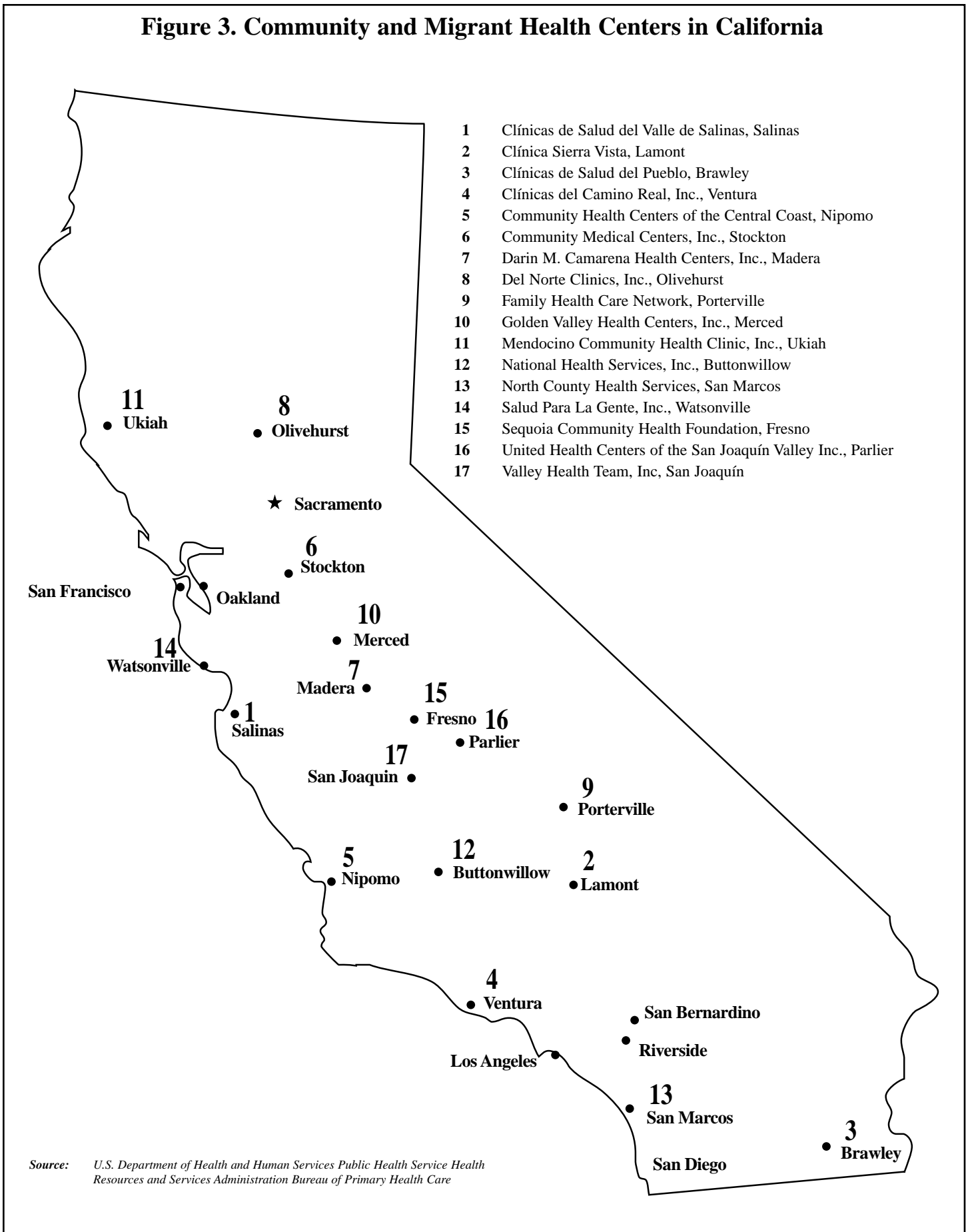
Social Science and Healthcare Access

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

Healthcare 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, 1995, 1992, 1986; Galarza, 1964;

Figure 3. Community and Migrant Health Centers in California



Source: U.S. Department of Health and Human Services Public Health Service Health Resources and Services Administration Bureau of Primary Health Care

Table 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
<i>Sources: Alvarez 1985; Ciesielski et al. 1994; Dever 1993; Littlefield 1987; Maguire 1972; Mines 1982; Ruducha 1989; Slesinger 1979, 1993; Vaughan 1993; Wilk 1986, 1993.</i>	

Harthorn, 1998; Johnson, 1985; Martin and Martin, 1994; Slesinger, 1992 Trevino et al., 1996; Villarejo, 2000; 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 healthcare access.

Certain studies on healthcare access among Latino immigrants examine how underlying cultural and social processes influence access to medical services (Bade, 1993; Chavez, 1986; Kearney et al., 1987; McGreevy, 1993; Scheder, 1988). 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 when they address access among a new immigrant group. Bonnie Bade’s work on healthcare access among Mixtec farmworkers focuses on unique cultural perceptions among this Mixtec speaking group who have recently participated in California agriculture (Bade, 1993).

Other investigations examine how structural and policy variables affect access to medical services. 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 since it examines how structural health policies influence potential and realized healthcare access among California resident farmworkers.

Overall, this study asserts that structural policies inherent in public and private health insurance programs for farmworkers are determinants of access to medical services. Medical anthropologists, utilizing the theoretical framework of the political economy of health, challenge healthcare 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). 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 healthcare 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 healthcare policies for low-income farmworkers in California since access to medical services is understood as a social process determined by the characteristics of the healthcare 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.

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.

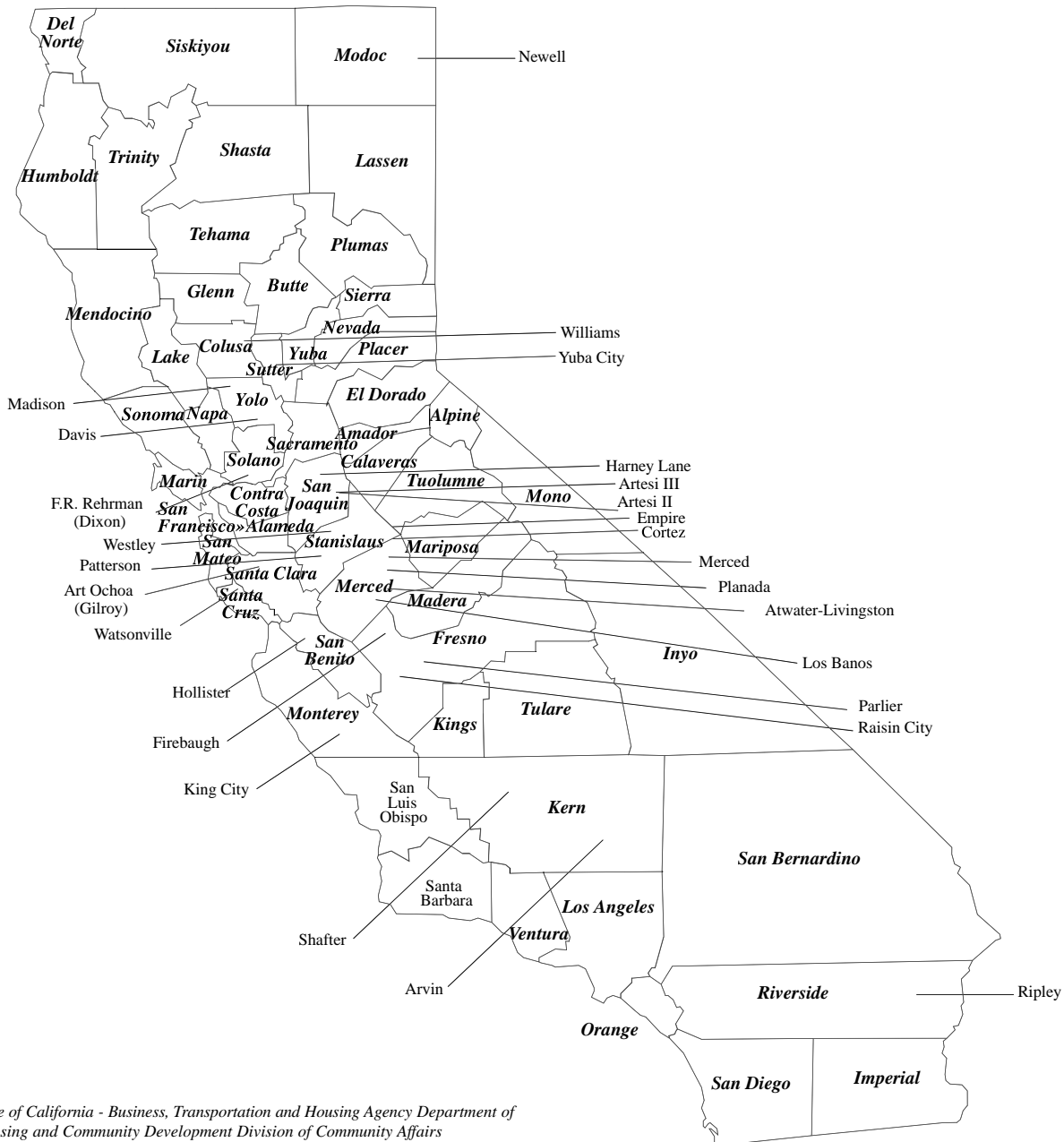
Fieldwork occurred over a 6-year period. Beginning in November 1994 and ending June 1996, in-depth interviews with 75 key informants provided the necessary background for the development of the questionnaires. This was followed by a 2-month pre-test of the structured questionnaire in which farmworker households were interviewed at the Art Ochoa Migrant Housing Center in Gilroy. From February 1997 through June 1999, farmworker households in Mecca were interviewed as were farmworker advocates, healthcare 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 household had at least one full-time farmworker for at least nine months that year. Of the 238 adults, 180 identified themselves as full-time farmworkers.

Field Sites

All households interviewed 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 in Gilroy in Northern California.

Figure 4. State Migrant Family Housing Centers in California



Source: State of California - Business, Transportation and Housing Agency Department of Housing and Community Development Division of Community Affairs

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. Figure 4 illustrates the location of this migrant family housing center.

More specifically, the Art Ochoa Migrant Housing Center has 96, 2-bedroom units available to migrant farmworker families from May through October. In 1995, data gathered by the Office of Migrant Housing in Sacramento indicated that 70% 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.

From August through September 1996, 36 farmworker households were interviewed at the Art Ochoa Migrant Housing Center. Thirty-one of these interviews were included in the analysis for this study, which represents 32% 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, the author interviewed, worked, and lived in Mecca. Mecca is located in the Colorado Desert in an unincorporated area of Southeastern Riverside County. Mecca is a 1-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 officials, estimate the year-round population at around 5,000, most of whom are farmworkers. This 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% Latino – 91% Mexican ancestry (Azevedo, 2000).

Three agricultural cycles and the fluctuations in Mecca’s population at both peak and low seasons were observed. Farmworker families at six subsidized complexes were interviewed. A small sub-sample of households living in trailer parks were also interviewed, as well as farmworker families living in private homes financed by Housing and Urban Development (HUD).

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. Site visits were conducted at several Community and Migrant Health Centers throughout California. These semi-structured interviews and clinic visits pointed to key issues salient to farmworker healthcare access.

During the second phase, from August through September 1996, 36 farmworker households were interviewed at the Art Ochoa Migrant Housing Center. 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, and one participant was not a farmworker.

For the duration of the fourth stage of this research project, from September 1998 through March 1999, data from the survey instruments was input into two database programs. Simple descriptive statistical analysis was completed using, among other software, SPSS.

For the fifth phase of this study, April 1999 through July 1999, semi-structured qualitative interviews with key informants were completed in Mecca.

This section provides information on the survey questions. Most interviews with farmworker households took, on average, 90 minutes. 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 healthcare providers in their homebase residence and, also, when they migrate northward.

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 asked whether 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, even though most farmworker households in this sample lived less than a mile from a primary health clinic.

Farmworkers also revealed 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.

This information was collected in order to understand which farmworkers and their dependents utilize medical services and other public programs. This research 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 concerns about their medical needs and medical services designated for them, and their ability to pay for healthcare.

Defining farmworker households was a critical methodological issue. This study focuses on farmworker families living primarily in subsidized housing. Excluded 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 1995-1998 seasons. A farmworker household in this study was defined as a family unit living in the dwelling at the time of interview. The survey gathered data on each member of the farmworker household.

Sometimes more than one household was living in a single-family dwelling; this typically meant that two or more families were living together. If both households qualified, each was asked to participate in the study. Furthermore, in the apartment complexes occasionally one household that was interviewed moved out and another qualifying household moved into the same dwelling. Overall, two dwelling units contained six households. However, most households participating in this study were comprised of simple nuclear families – parents and their children living together in one dwelling.

A household was designated as “migrating” or “non-migrating,” depending on whether 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.

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 tended to live in poor housing conditions when they traveled north for agricultural work. It should 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 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 to avoid interfering with the job-hunting process. It is also important to note that in most studies involving human subjects, researchers were required to obtain written consent from each 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. Written consent may have intimidated some potential participants since it leaves a record of who participated; this could put subjects at risk. 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, researchers traveled by foot door-to-door. If a household agreed to participate, oral consent was obtained and a written and oral introduction was presented. This "fact sheet" was given to participants if they agreed to be interviewed.

Sampling a Difficult Population

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 recommended a non-probability sampling strategy (Lepkowski, 1991). In this study, the ethnographic approach began with in-depth, semi-structured interviews of farmworkers, farmworker advocates, and medical care professionals. Discussions led to the development of a sampling strategy that, in theory, reflects 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.

Efforts were focused on the subsidized apartment units since heads of household must prove legal status in the United States. As a consequence, this study primarily focused on California-resident farmworker households who tended to qualify for some public benefits, based on low income and legal resident status. Non-probability sampling, that yields what is known as a cluster sample, was used (Bernard, 1994). The clusters sampled were designated, subsidized, government housing units located in Santa Clara and Riverside counties. More specifically, attempts were made to contact all families living 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. A sub-sample of farmworker families living in trailers, HUD homes, and private apartments in Mecca, known as "convenience sampling," was also conducted. Despite the inherent weaknesses of this type of sampling strategy, 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 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, healthcare 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. Permission was obtained to interview farmworkers at temporary migrant housing centers in California by writing, phoning, and, eventually, meeting California Office of Migrant Services representatives. Locally, at the migrant center in Gilroy, the study was discussed at 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. The study was explained in Spanish and English to the residents. Therefore, most people understood interviewers would be knocking on their apartment doors. In Mecca, this research project was introduced to all the

apartment managers and permission was granted to visit the various complexes. The project was also discussed at two community council meetings and at two well-attended school parent-teacher conferences held at the Mecca Elementary School.

Recruitment of healthcare 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.

In short the researcher lived, worked, and conducted research where a large concentration of farmworkers lived. This research methodology can be defined as community-based because the help of both farmworkers and local farmworker advocates were sought in the survey's development. 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 the researcher 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) information.

In practice, this involved interviewing farmworkers in their home environment, giving the 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 or discrete pieces on information. However, near the end of the interview, several questions were more open-ended, giving the farmworkers a chance to elaborate on their experiences – good and bad – with healthcare providers in the U.S. and Mexico. To facilitate recall, researchers used several visual aids.

Once researchers have the 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 were more difficult to interpret

than others because the meaning is sometimes lost in the translation. After transcription and translation, this narrative data was analyzed by dividing the textual passages into 38 major themes and, then, organized portions into 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.

In addition to the survey data and formal interviews, 11 hardbound volumes of field notes, totaling more than 4,000 pages of handwritten notes, were collected. These field notes include minutes of meetings, daily descriptions of life in Mecca, receipts, hand-drawn maps, etc. Moreover, more than 600 photographs were taken of farmworkers and their families in their homes, schools, town events, and even the fields where crops were harvested. Archival research was completed at the Mecca Public Library and the Imperial County Community College to get historical accounts of the region. By combining participant observation and systematic data collection by means of the survey, the researcher was able to use the strengths of each method to overcome their inherent weaknesses.

Demographics

Household Sample

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

Table 2 describes the household sample by locations and migration status.

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 were interviewed. In Southern California, 99 households from Mecca participated in this study. In Mecca, 64 households came from six different subsidized government rental units and 35 households

Field Location	Migrating Households	Non-Migrating Households	Total Households
Gilroy	30	1	31
Mecca	44	55	99
TOTAL	74	56	130

from other types of dwelling units: eight households from privately rented apartments, 12 households in trailers, and 15 from homes financed by HUD.

An approximate estimate of the percentage of farmworker households sampled in subsidized rental housing units shown is in Table 3.

	<i>Apartment Data</i>	<i>Sample Obtained</i>
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*	64/142**
*51.6% were farmworker households		
**45% of all farmworker households were interviewed		

As of July 1998, there were 275 low-income government-subsidized rental dwelling units in Mecca. About 142 of them had one or more adult members listed as working for at least nine months in agriculture and approximately 45% of the farmworker households living in subsidized housing Mecca were interviewed. This is only an approximation since the number of farmworkers living in these units varied each month. However, from May through July more farmworkers were present than at other times during the year. Neighbors of farmworker households in these subsidized units included construction workers, gardeners, nurses' and teacher's aides, daycare workers, mechanics, and grocery store personnel. Many started out as farmworkers, but changed career trajectories when given the opportunity. Overall, interviewees lived in 130 separate households and they had at least one female adult living there; 108 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. Their birthplaces were also discussed.

Birthplace

Table 4, Table 5, and Table 6 illustrate where members of farmworker households were born. As they indicate, more than 90% of the adult women and men were Mexican-born. Of the 322 children living in the

household, 70% were born in the U.S. while 30% of the children were born in Mexico. In 26 out of the 126 households reporting children under 18, many older children were born in Mexico while the younger ones were born in the U.S. In any given household, some members could be Mexican Nationals while others could be American citizens. This creates what Leo Chavez calls a "binational family" (Chavez, 1994). Differences in birthplaces lead to differences in legal status. The concept of a binational household gains importance when examining the legal status of farmworkers.

	<i>Non-Migrating</i>		<i>Migrating</i>		<i>Total</i>	
	<i>N=55</i>		<i>N=75</i>		<i>N=130</i>	
Mexico	50	89.0%	67	90.5%	117	90.0%
United States	5	9.0%	8	11.0%	13	10.0%

	<i>Non-Migrating</i>		<i>Migrating</i>		<i>Total</i>	
	<i>N=41</i>		<i>N=67</i>		<i>N=108</i>	
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%

	<i>Non-Migrating</i>		<i>Migrating</i>		<i>Total</i>	
	<i>N=123</i>		<i>N=199</i>		<i>N=322</i>	
Mexico	45	36.6%	52	26.1%	97	30.1%
United States	78	63.4%	147	73.9%	225	69.9%

	<i>Non-Migrating</i>		<i>Migrating</i>		<i>Total</i>	
	<i>N=55</i>		<i>N=75</i>		<i>N=130</i>	
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%

	<i>Non-Migrating</i>		<i>Migrating</i>		<i>Total</i>	
	<i>N=41</i>		<i>N=67</i>		<i>N=108</i>	
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%

Legal Status

Birthplace is closely related to socio-political status. Citizenship often determines what types of programs a low-income group qualifies for. As a whole, most adult farmworkers were legal immigrants while their children were most likely American citizens. However, this also reveals that 20% of the women were undocumented even though their husband was a legal immigrant or U.S. citizen. Table 7, Table 8, and Table 9 examine these trends in greater detail.

	<i>Non-Migrating</i> N=123		<i>Migrating</i> N=199		<i>Total</i> 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%

Among the adults, close to 80% of the women, and 90% of the men and children, were legally present in the United States due to their status as resident or an American citizen. These high percentages reflect the reality that the head of household in government subsidized rental units must be documented. Despite that, other immediate family members may not be. Another research goal was to understand the effect of legal status on healthcare access since binational households face unique dilemmas when accessing medical services.

Civil Status

The civil status of couples may influence the type of medical insurance that members of farmworker households qualify for. Marriage, for example, provides the opportunity for medical insurance for spouses and dependents if one of the adults has employment-based medical insurance. A single mother seems more likely to qualify for public medical insurance.

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

Table 10 presents findings on marital status and illustrates that 72% of all farmworker households interviewed contained a married couple. While 80% of the migrating households included a married couple, 62% of the non-migrating households included one. Moreover, 8% of migrating and 9% 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 being divorced.

Another way this data was examined was by collapsing 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 5. Examining the statistical relationship between civil status and migration is important because it provides another way to reinforce the distinctions between migrating and non-migrating farmworker households that ultimately impact access to medical services.

<i>Farmworkers Living * with Partner</i>		<i>Migration Crosstabulation</i>		
		<i>Migration</i> m	<i>nm</i>	<i>Total</i>
Farmworker alone	Count	9	16	25
Living with Partner	Count	66	39	105
Total	Count	75	55	130
Chi-Square Tests				
	<i>Value</i>	<i>df</i>	<i>p<.025</i>	
Pearson	5.967	1		
Chi-Square				
<i>Source: Kathryn Azevedo Dissertation 2000</i>				

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 partners. For non-migrating heads of household, 16 lived alone and 39 lived with partners.

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 suggests that, at least in this sample, the tendency for migrating households to contain couples living together 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, generally 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.

Average Ages of Adults

It is also worth the time to examine the average ages of the adults in this sample. Table 11 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.

	<i>Non-Migrating</i> (54 Women+57 Men)	<i>Migrating</i> (72 Women+32 Men)	<i>Total*</i> 215 adults
Female N=126	35.42	35.14	35.26
Male N=89	40.47	37.81	38.76

The average age of women, in both migrating and non-migrating households, was 35 years. Average age of migrating men was 38 years, and average age of non-migrating men was 40 years. Total average ages of adults in this sample lie between 35 and 40 years old, indicating that the farmworkers interviewed were relatively young and very likely to be supporting children under 18.

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 12 illustrates the number of children in both migrating and non-migrating households: each household averaged almost four children.

	<i>Non-Migrating</i> N = 52 households	<i>Migrating</i> N = 74 households	<i>Total*</i> N = 126 households
Kids <18	3.92	3.68	3.77
N=322			

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. Of households in this studied, 126 reported having a total of 467 children. Over three hundred (322) of those children were under 18 years of age and living in the household at the time of the interview. Figure 6 provides more detail on the number of children reported by heads of farmworker households, and also illustrates that the majority of households had four or fewer children.

<i>Number of children per household</i>	<i>Number of Households</i>	<i>Total Children</i>
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

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 13 reveals the distribution in ages for children living in migrating and non-migrating farmworker households.

Age of Child	Migration Status		Count
	Migrating	Non-migrating	
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

The average age for children in both groups was 8 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. 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, at times need medical attention for reproductive services. Knowing the number of children per household and ages of these children helps gain an understanding about the medical needs and subsequent access issues that may arise for a given farmworker household.

Education of Adult Members

Information about the education levels attained by adults living in farmworker households is also relevant to understanding their access to medical services. Tables 14 and 15 represent the educational level of the adult women and men residing in farmworker households. Overall, the

	Non-Migrating N=55		Migrating N=75		Total N=130	
	No Education	4	7.2%	3	4.0%	7
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	55	100.0%	75	100.0%	130	100.0%

	Non-Migrating N=41		Migrating N=67		Total N=108	
	No Education	1	2.4%	2	2.9%	3
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	41	100.0%	67	100.0%	108	100.0%

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 U.S. high schools. Otherwise the data represent education received in Mexico.

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 all people reveals that most research participants had less than a high school education. More specifically, 22.5% of migrating women and 14.7% of migrating men had attained a high school education or beyond, whereas only 12.6% of non-migrating women and 7.2% 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 it cannot be statistically supported 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. On the contrary, none of the non-migrating farmworkers had at least two years of university education.

Employment Characteristics

It is engaging to examine the division between adult farmworkers and non-farmworker spouses. To clarify further, there were 238 woman and 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 worked in another occupation, and, of those who remained, one was retired, and another disabled. In summary, of the 238 adults in this sample, 180 were farmworkers.

Figure 7. Companies Employing Farmworkers in the Study

Adope Packing	Fever Ranch	Sam World
Alco Packing	Fresh Express	Sawyer American
Amazing Coachella	Golden Acre	Sea Son
Bell Farms	Imperial Western	Sierra
Borello Farms	Jorge Ochoa Farms	Silver Canyon Farms
Bruce Church	K&W Farms	Sojaras
Bud of California	Kitagawa & Sons	Sonora Packing
Cardinal	Levimarra Vineyards	Sun Date
Chester Enterprise	Mission Packing	Sunshine
Christopher Ranch	Mona	Sun World
Coachella Citrus	Omar	Tanin Murantle
Codopa Dates	Oscar Ortega	Tudor
Crown Hill	Pan American	Valley Pride
Desert Fresh	Rancho American	Vege Pack
Dimara	Richard Bagdasarian	Venus Ranch
Dole Fresh	Ripaul Sorting	Zepeda Labor
Escamilo & Sons	Rivera	

Figure 8. Field Jobs Worked by Farmworkers

<i>Crop</i>	<i># Laborers</i>
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

Companies and Contractors

Farmworkers in this study worked for many companies, most of which were relatively small. Some companies listed in Figure 7 are no longer in existence due to closures or mergers.

Figure 8 demonstrates that most research participants were, in fact, those who worked directly with the crops in the fields or in 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 chiles. 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%) of farmworkers worked exclusively for one company year round. Multiple employment means less consistency in employer-based medical insurance.

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%, 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% 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%) were involved in grapes, 17 out of 55 (31%) harvested citrus, and two out of 55 (3%) 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 16 and 17 summarize the hours and the number of years worked. 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 worked slightly fewer hours than men. Based on researcher observation, women fit work around childcare and household duties. This trend was also reflected in Table 17.

	<i>Total</i>	<i>Migrating</i>	<i>Non-Migrating</i>
<i>Male N = 105</i>	43.81	43.42	44.47
<i>Female N = 75</i>	39.06	40.16	37.90

	<i>Total</i>	<i>Migrating</i>	<i>Non-Migrating</i>
<i>Male N = 105</i>	14.75	13.6	16.78
<i>Female N = 75</i>	8.69	8.90	8.46

Overall, men worked more years in agriculture. 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 that, in the absence of day care, some women stay 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 18, 19, and 20 include self-reported data on average monthly salary, unemployment compensation, AFDC/TANF (welfare checks), WIC coupons, and food stamps. More specifically, farmworkers estimated 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 \$1,350. Overall in the sample, migrating farmworkers earned more per month than non-migrating farmworkers.

It is important to point out that this average monthly estimate of income from salaried work often included pooled salaries. Table 19 illustrates unemployment income reported by farmworker households. Overall, 60% of farmworker households reported receiving unemployment within the year prior to the interview.

	<i>Total</i>	<i>Migrating</i>	<i>Non-Migrating</i>
<i>Average Mo. Salary</i>	\$1,350.00	\$1,470.00	\$1,185.00

	<i>Total</i>	<i>Migrating</i>	<i>Non-Migrating</i>
<i>Unemployment</i>	60.0%	66.0%	59.0%
<i>Compensation</i>	\$310.62	\$290.26	\$343.71

	<i>Total</i>	<i>Migrating</i>	<i>Non-Migrating</i>
AFDC/TANF	9.16%	6.0%	9.0%
	\$394.25	\$425.33	\$375.60
WIC Coupons	34.5%	34.7%	34.1%
	(38/110)	(24/69)	(14/41)
Food Stamps	22.1%	20.0%	25.0%
	(29/130)	(15/75)	(14/56)

Migrating farmworker households (66%) in this sample were slightly more likely to report receiving unemployment income than non-migrating households (59%). 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 Employment Development Department (EDD) in California. Community workers, advertisements in the Spanish news media, and farmworkers themselves aggressively distributed information about EDD services. Table 20 illustrates the use of public assistance by members of farmworker households.

The use of public assistance in the form of welfare checks (AFDC/TANF), WIC coupons, and food stamps was relatively low. Less than 10% of all farmworkers households reported receiving welfare checks within 12 months prior to the interview date. Approximately 34% of the families received WIC food coupons, and approximately 20% 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 note that this self-reported data is probably an underestimate of total monthly income. For example, farmworkers also earn additional income by renting out furniture, re-selling jewelry, medicine, and other items purchased in Mexico, providing child care, making floral arrangements, and working for commission-based cosmetic companies like Mary Kay and Avon. If farmworkers are literate in English, they may charge for helping neighbors' complete forms. Some farmworkers earn income by fixing appliances or cars; if farmworkers have a vehicle, they may charge for rides. During periods when they receive unemployment compensation, some work for cash by doing gardening or taking garbage to the dump. Some women make tamales, tortillas, and other food items, and then sell them to neighbors. There continues to be a huge underground and unrecorded informal economy in both Mecca and Art Ochoa. Some farmworkers even sold jewelry and distributed Mary Kay Cosmetic's catalogs as they pruned grapes.

Farmworker Lifestyle, Work, and Health

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 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 "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 on the outskirts of the rapidly growing and expanding Silicon Valley. Agricultural land is increasingly converted into housing, shopping, or office buildings, so the Art Ochoa housing complex is now almost hidden by the highways. Within its vicinity, Art Ochoa is located next to a few privately owned labor camps that house single, migrant male workers. Across the street is a waste treatment plant. Surrounding Art Ochoa are agricultural fields, railroad



Inside an apartment at Arturo Ochoa Camp.

tracks, and Highway 101. Within a mile, there is a department store and a primary healthcare medical clinic; within two miles, there is a 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 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; most households 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 2-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 enclosed by a fenced, and pets are not allowed. Each unit has a small front yard where some residents 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 and most households have telephone service. A few have cable television. Families 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, Ariz. Others had a residence in the California towns of El Centro, Holtville, and Mecca in Imperial and Riverside Counties. Migrating farmworkers 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 migrated. Some families even traveled once or twice a month to their homebase to make sure everything was in order. Therefore, they were preoccupied with maintaining two residences simultaneously. Most of the households 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 had to have access to at least one vehicle. As one male farmworker pointed out, a well maintained automobile reflects their livelihood. Farmworkers living temporarily at Art Ochoa still have a substantial commute because their employment takes them to Hollister, Salinas, Monterey, and Half Moon Bay, which can be up to 2.5 hours away. Driving in the foggy coastal areas, where small 2-lane roads are characteristic, is a known daily hazard. Farmworkers live with the fear of car accidents and a few experienced serious injuries from previous accidents that occurred while traveling for work. With the exception of elementary school buses, there is no public transportation serving farmworkers in this area. Despite the presence of at least 100 stores nearby, 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 at Art Ochoa during the day – they are completely isolated. In addition, the pay phones for Art Ochoa residents are also used by the general public, sometimes resulting in long waits to use them.

Residents at Art Ochoa communicate with their neighbors and most know each other by first names. Neighbors sometimes share phone lines, 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. Others 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 often arise before dawn and are in bed usually before 9:30 p.m. Almost everyone speaks Spanish; children are usually bilingual and sometimes 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 interview women since they were always busy. When not in the fields they were cooking, watching children, shopping, cleaning, selling, attending social events, or helping someone else with chores. Men occasionally 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 vehicles or tending gardens. Young boys ran around the complex playing soccer, football, or riding bikes. Girls also rode bikes, but they often play inside. Adolescents seldom “hung out” since loitering was not permitted. Many, in fact, work in the nearby stores if they have transportation. Men and teenagers usually went 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 interact with Art Ochoa residents regardless of their isolation and location

By and large the Art Ochoa was peaceful and well maintained. 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 were instances of petty theft and vandalism, but these incidents were uncommon. Nevertheless, residents have a few significant concerns.

The air often smells bad due to nearby agriculture and the waste treatment plant located across the street. The area is poorly lit and there are few services available within walking distance.

Healthcare Services at Art Ochoa

Rota-Care volunteers staffed the on-site medical clinic weekly in order to provide free basic check-ups and referrals. Since there was no on-site lab or pharmacy, and the clinic were sometimes staffed with non-physicians, clinic staff was limited to providing very basic primary healthcare 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

healthcare services. More specifically, one female farmworker commented that many farmworkers arrive home between 9 and 10 p.m. and she suggested that the clinic remain open until late at least once a month to accommodate these farmworkers.

All of the households reported knowledge of the Rota-Care free clinic and more than 90% of the heads of households reported they knew where to buy medicine, where the nearest emergency room is located, and where the nearest subsidized full service primary healthcare clinic is in San Martin. This knowledge is based on previous attempts by family and neighbors who sought healthcare 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 profit. Migration is either a planned, annual event, or a sudden decision made when work is scarce in the homebase area. Most farmworkers 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 daycare. In fact, when reading about the programs for farmworker families, many of which started in the 1960’s, there is 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 housing at this complex allows families to migrate and stay together, and is a major influence on decisions to migrate to the Bay Area. If a family is not guaranteed a space at Art Ochoa, the adult male in the family may be the only person to migrate. The rest of the family would probably remain behind.

Previous experiences also influence the decision to migrate for agricultural work. For example, many farmworkers in this study reported that the working and living conditions in Huron were very bad. Due to Huron’s reputation, farmworkers reported that male farmworkers would migrate to Huron alone after the work had ended in Gilroy, while the rest of the family would return to their homebase. Most farmworkers in Gilroy reported an overall positive migrating experience while living at the Art Ochoa Migrant Housing Center. First-time residents,

however, report a more difficult migrating experience since they have to learn where everything is located, adapt to the climactic changes, and develop effective social networks.

As the business of agriculture has evolved, due to technology advancements and improved irrigation, work is becoming available year-round in some rural California communities. Some of the distinct contributions of this study lie 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.

Living and Working in Southern California

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, which include grapes, and citrus fruit, grow in this desert climate when irrigated by the Colorado River.

Farmworkers homebased in Mecca work primarily in the Coachella Valley. Families who migrate during summer from Mecca often travel north to Gilroy or Bakersfield.

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 Riverside County. However, 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 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° 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. 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 Arizona (Foulkes, 1985). The mines and the railroad attracted people to this region in the early 1900's. In 1904 the area became known as Mecca, but this land has historically been home to the Chemehuevis and Cahuilla peoples for more than 1,000 years (Laflin, 1998). Currently, interspersed throughout the Mecca area are several parcels of Native American land belonging to the Cabazón and Torres-Martínez 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 vineyards and 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% of its residents speak Spanish as a primary language and where the majority 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 history.

Job instability forces many farmworkers to change jobs frequently. In fact, some farmworkers could not even remember the name of the company that employed them and many had to look at their pay stubs. Agricultural employment in California operates in a competitive, time-sensitive, market-specific, and weather-dependent environment. Agricultural conglomerates increasingly replaced small family farms. It is in this environment that farmworkers and their families' work.

Mecca in the 1990's

Despite the insecurities inherent in this business, Mecca continues to grow due, in large part, to the booming agricultural industry. Currently, Mecca is quickly changing into a major farmworker community. Although the 1990 Census reports close to 2,000 people reside in Mecca, the figure is actually closer to 5,000-6,000, according to a variety of local agencies that

estimate the population on data from utility companies. Mecca, however, is still a small town where most people know each other. There are at least three small, family-run grocery stores, a post office, a small library, two elementary schools, five formal daycare programs, four churches of different Christian denominations, a gift shop, one beauty salon, two restaurants, one laundry, one video store, one long distance telephone center, one hardware store, one income tax service, and four money order service centers.

Officially, the Mecca Health Clinic, located in the Nueva Vista apartment complex, provides licensed primary healthcare services from at least one physician, two nurse practitioners, two nurses, and several medical assistants. A laboratory technician performs basic laboratory procedures for patients of the Mecca Clinic; sophisticated tests are sent to a regional laboratory. A pharmacy, located in nearby Indio, delivers medicines ordered by Mecca physicians for clinic patients. However, Mecca residents 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 perform free dental exams for school age children. There are also alternative Mexican healthcare practitioners, with varying degrees of formal training, practicing in undisclosed locations.

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. In 1999 there were about 300 homes, 275 subsidized apartment and home rental units, 500 trailers, and 100 mobile homes there. During peak seasons in 1998 and 1999, from April through July, migrant farmworkers lived in approximately 200 automobiles parked in grocery store parking. There were also vehicles, with farmworkers living inside, parked along isolated irrigation canals and on small ranches. Of those living in the cars, more than 90% were men with families in Mexico. Occasionally, there were a few young women. Most were homebased in the northern states of Mexico; the majority came from Baja California Norte. A few of the men were homebased in Arizona. All the men spoke Spanish and many understand some English. A few were trilingual in Brazilian Portuguese, Spanish, and English.

These migrant farmworkers 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 migrants living out of their cars were a few local homeless people who lived under the palm trees. The homeless were usually bilingual. Occasionally the homeless would compete with the migrant men for work in the fields. Many of these homeless men experience mental illness or battle substance abuse and are sometimes mistaken for migrant farmworkers. They are occasionally profiled by the local and regional press in 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. They are known as the Tarascan people from the state of Michoacán in Mexico and speak a language called "Purépecha." Most work in the citrus groves. These farmworkers are one of the most exploited groups living in Mecca and experience much discrimination. 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 workers and are systematically exploited by crew leaders. They earn on average \$1 to \$2 less per hour than Spanish-speaking farmworkers. The local grocery store staff cashes their checks and observed this differential in pay.

On the outskirts of Mecca, there were at least 10 privately owned trailer parks. Many of these trailers 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. Struggles to adequately house permanent and migrant farmworkers who travel to Mecca looking for work is on going. Even though Mecca is designated as a homebase location, it is also where people migrate for agricultural work. Housing continues to be a pressing issue.

Permanent Mecca residents face the problem of creating adequate subsidized housing for farmworkers and other low-income residents. Furthermore, 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 healthcare 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.

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 emphatically stated that Mecca provides a "family oriented lifestyle." Farmworkers with children in Mecca often follow similar routines. At 5:30 a.m. they drop off their children at day care. The day care staff sometimes takes some of the older children to school at around 8 am. Parents are in the fields by 6 a.m. and work until 2:00 or 3:00 in the afternoon. From work, most farmworkers go directly to school or to pick up their children. In fact, in Mecca the only predictable traffic jam occurs every weekday from 2:30-3:30 when the school day concludes. Most farmworkers are at home by 4 p.m. with their kids. They shower and change clothes. Women usually begin to prepare dinner; kids play and do their homework, or 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 a.m. until early afternoon.

Their weekend actually begins on Saturday afternoon and 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 where their next 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, elaborate on various aspects of life in Mecca in the 1990's 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 (or) in the fields. We had to see where other needs were – school, 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... where 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 20 minutes or even in a half 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, 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 do you see?

Farmworker: Well, the needs are basic needs. For example, medical attention for children. Even though we have a health clinic, there is so much demand and so few medical personnel to attend to the people... 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, 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... these problems 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. 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 needs in different areas. 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, which is so big.

Interviewer: How many people live here?

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

Interviewer: They say that there are only 1,800 people, 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 here 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... 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.

This passage is especially powerful because this farmworker and former community health worker revealed many 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 conditions most common in children – anemia, intestinal parasites, and lice.



Bathroom facilities in grape fields of Mecca, Calif.

Medical Conditions Reported

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 grapes' skin. 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 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.

Clinic Staff Observations

Clinic staff confirmed that farmworkers were often seen for pesticide-related problems. 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. 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.



A farmworker helps a friend remove sulfur dust from her eyes.

Medical Concerns Unique to Migrant Farmworkers

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.

Some migrating farmworkers said the experience 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 female farmworker stated that when she migrated to Northern California, she and her family lived in a complex that housed six families. However, all six families -- 50 to 60 adults and children - - shared one toilet facility. Another farmworker pointed out that her children get lice when they are migrating for work. Many 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. Farmworkers who migrate to a new location for the first time also find it difficult to locate nearby medical facilities.

On the other hand, a small percentage of farmworkers interviewed indicated that they had no 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. This process acquainted farmworkers with nearby primary healthcare clinics.

Based on these observations, there are other health risks associated with migrating for agricultural work. In many households, diets also change when they migrate. More specifically, 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 Farmworkers

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 Mecca, they also

experience some important health concerns. The following interview passages with non-migrating farmworker reveal some of these tendencies.

Non-migrating farmworkers live and work in the harsh desert climate of Mecca during the summer. Mecca is located near the polluted Salton Sea and, during the summer when humidity rises and temperatures climb to 120°, thousands of birds and fish die. There is a pungent odor that lingers into the evening hours. In the extreme heat, insects multiply, creating additional 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 runoff. 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, troublesome 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 the day and to the cold of night.

At the heart of this study are distinctions between the migrating and non-migrating farmworker households homebased in desert southwest towns like Mecca. Residents interviewed upstream at Art Ochoa followed a particular routine in Gilroy while simultaneously trying to maintain their homebase household. 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 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 quickly understand the different labor structures 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 by 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 campo porque te encuentras con muchas amigas, muchos compañeros, 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 they do, 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. Migrating farmworker households would, it was anticipated, experience a much greater illness burden. Instead, 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.

Access to Medical Services

Among agricultural laborers working in the United States, it is estimated that between 13% and 20% utilize healthcare services targeted towards them (Benavides-Vaello et al., 1994; Wilk, 1986; Rust, 1990). But one asks why so few farmworkers use these services and what does access to healthcare services really mean? There are several issues related to potential and realized access to medical services that may help address these questions.

First, there is a discussion of potential access indicators: farmworker knowledge of the geographic location of medical facilities; medical programs targeted to low-income households, and, the varying degrees of medical insurance coverage by farmworker household members. Then factors that impact realized healthcare access, the utilization of medical services, are examined. Included are self-reported barriers to medical services, and 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 healthcare medical facility.

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% of the sample, knew where primary healthcare clinics and the nearest emergency rooms were located. The reason is probably that, in both research sites, the primary healthcare clinic was located in close proximity to where most farmworker households lived. In Mecca, there is a primary healthcare clinic run by Clínicas 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 healthcare 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 Los Angeles' USC Medical Center. All three of these facilities were much farther away, but treated the population studied at subsidized rates. Upstream, in Gilroy, migrating farmworker households in this sample were treated at St. Louis Hospital or the Santa Clara Valley Medical Center. These hospitals are about 30-90 minutes away.

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, 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 approval notice, he was just waiting for it in the mail.

Interviewer: Between 1995-97, did you encounter difficulties accessing medical services?

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 to get people to pay. But they should offer some kind of service before sending you two 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 me and it was to him. 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 (March 5, 1997).

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 high level of potential access to basic primary healthcare 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.

Public, Private, and Charity Health Programs

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.

Access for Infants and Mothers

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 2% 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 (7.5 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. 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.

Adolescent Family Life Program

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 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. 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 Tarascan-speaking youth in Mecca. Tarascan-speaking youth are more likely to become parents below the age of 15.

BabyCal Campaign

The program's target group 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, which included a tote bag, a health diary, and some trial samples of baby products, for those receiving pre-natal care under the Medi-Cal program. BabyCal posters on buses and other public places encourage expectant women to call the toll-free number to seek medical services (State of California, 1998).

California Black Infant Health Program

About \$4 million in state funding has 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 healthcare programs in 16 health jurisdictions can apply for supplemental funding if they serve African-American women and children. This program is available because,

in that community and at migrant health centers in these jurisdictions, it also serves 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 of Imperial County (State of California, 1998).

California's Prevention Program

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% 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, hearing, and lead testing, specific laboratory testing (tuberculin, sickle cell, urinalysis, hemoglobin/hematocrit, Pap spears), and preventative dental care exams for children younger than three.

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 Aug. 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. According to state administrators, eligibility is based on self-reported income only, not on documentation status. Children do not have to be citizens in order to qualify for this program. Unlike the Medi-Cal program, the application process is simple – only proof of county residency, not income or documentation status, is required. There is great potential for children of farmworker households to utilize these programs.

California Children Services

Children younger than 21, 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% of the family income. The CCS program treats children with specific diseases and these children are often permanently disabled. 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 migrants 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 this study, only 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. It is sometimes very difficult to get what parents see as an adequate amount of physical and occupational therapy for 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 healthcare 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 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 healthcare, and 24-hour telephone service. This program does not cover inpatient specialty hospitalization.

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, 1998).

California School Health Services

In California, there are more than 60 school-based healthcare 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, 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 is a mixture of state and federal funds and had a 1997 budget of almost \$1 billion. 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 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, 1998).

Comprehensive Perinatal Services Program

The Comprehensive Perinatal Services Program 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, information about whether members of farmworker households took advantage of this program (State of California, 1998).

Disability Insurance

Disability Insurance is administered in California by the Employment Development Department. If farmworkers qualify for unemployment benefits, then Disability Insurance, a program completely financed by contributions from employees and employers, usually covers them. In this study, I only encountered one farmworker 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% of the farmworkers in this study reported receiving unemployment benefits, it can be inferred 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 and Treatment

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% of the Federal poverty level. This 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, dysplasia services, and other forms of reproductive health education and counseling. This program pays for many medical visits at the Mecca Clinic and enrollment is simple.

Clinic staff members determine if the person seeking services is a resident of the county and, if so, a short application is completed at the provider's office. It is activated instantly on-site, and newly enrolled patients leave with a client benefit card the same day (State of California, 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 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 rendered 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, \$2 million was allocated for nutritional assistance programs to legal-immigrant migrant farmworkers (State Action on Immigrant Food Assistance, 1999). Only 22% 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 very confusing to figure out which immigrants can receive them. As of this writing, undocumented persons do not qualify for the Food Stamp Program. They may 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.

Healthy Start Support Services for Children Act

In a school district like Mecca that has a Healthy Start Program, 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. In Mecca, Healthy Start coordinated free medical, eye, hearing, and dental exams through local agencies that donated these services. Other goals of the Healthy Start programs include mental health counseling, 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.

Health Insurance Plan of California

This program, which has no income test, is designed for employees of small businesses and their dependents. The program's main focus 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 took advantage of it.

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 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.

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 uninsured California children. Uninsured school-age children whose family income is 201-275% 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. 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 and this program ends on Dec. 31, 2002.

Major Risk Medical Insurance Program

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, MRMIP 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% 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 and do not qualify for other types 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.

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 in federal funds and \$10 billion in California state funds. About 5.1 million California residents, approximately 16% of the state population, receive Medi-Cal benefits that are administered by the California Department of Health and Human Services (Medi-Cal Policy Institute, 1999). As of July 1998, 157,239 Medi-Cal recipients received benefits in Santa Clara County totaling \$414 million dollars. In Riverside County, nearly 200,000 people received Medi-Cal benefits totaling \$3.57 million (Medi-Cal Policy Institute, 1999).

To become eligible for Medi-Cal, people must complete a very detailed application process and meet property, income, institutional, residence, and citizenship requirements (Medi-Cal Policy Institute, 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 interviews with farmworkers began, most non-citizen farmworkers were rendered 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 healthcare, the perception at the local level is that non-citizens still do not qualify for these benefits. In this research, 15% of the women, 12% of the men, and 67% 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. Members of farmworker households underutilize Medicaid programs because there is widespread confusion about who qualifies.

Partnership for Responsible Parenting

Begun in 1996, this program is essentially educational and designed to reduce the number of teenage pregnancies in California. As part of this program, \$53.6 million 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. The media campaign has reached Mecca and advertisements about teenage pregnancy can be found on the buses, television, radio, and in the clinics.

An additional \$8.4 million statewide enhances enforcement of California's Statutory Rape laws. 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 occurs even if the pregnant person does not want this to happen. This effort has instilled utter fear in these young women and they are 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. Community health workers have seen several girls pregnant at 13 and 14 years of age. These teens delay seeking pre-natal care because several Tarascan men have been jailed for statutory rape. 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 insensitive 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 for a teen mentor program although no aspect of the program has been implemented in the Mecca area (State of California, 1998).

RotaCare Program

The RotaCare program provides free medical services for migrant farmworkers at the Art Ochoa Migrant Housing Center in Gilroy. RotaCare Free Clinics began in 1989 by Rotary Club members in Morgan Hill, Calif. (U.S. Department of Health and Human Services, 1996). This program targets the homeless, migrant workers, and immigrant populations who are either uninsured or underinsured. In addition to the primary healthcare 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" (U.S. Department of Health and Human Services, 1996). Volunteers staffing the clinic at Art Ochoa usually work for six to eight weeks. Farmworkers interviewed at Art Ochoa appreciated this program. However, they pointed

out that services could be improved if the clinics were open longer, volunteers served longer terms, and more clinic staff were bi-lingual.

Women, Infants, and Children Nutrition Program

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 milk, juice, eggs, cheese, cereal, dry peas and beans, and peanut butter at no cost.

Workman's Compensation

By law, most farmworkers are eligible for Workman's Compensation Insurance if it can be proved that an injury occurred at work. All medical services should be completely covered. 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.

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, it is useful to look at what types of medical insurance coverage were reported by heads of households interviewed in this study.

Findings

Medical Insurance Coverage

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, give us some idea as to health insurance coverage among members of California farmworker households (Villarejo, 1999). In McFarland, the Department of Health Services attempted to screen every family with children between one and 12 years old. About 1,697 children were screened, which was 90% of the eligible population.

In the McFarland survey, 54% of the families interviewed reported some type of medical insurance coverage – 32% private insurance and 22% Medicaid (Villarejo, 1999). In the Parlier study, 39% of the families interviewed reported some type of medical insurance coverage – 25% private insurance and 14% Medicaid (Villarejo, 1999). The National Agricultural Workers Survey reports that 32% of farmworkers in California have some type of employee-based medical insurance (Rosenburg et al., 1998). As a matter of comparison, 58% of Latinos, 85% of Anglos, 82% of African-Americans, and 81% of Asians and others report having some type of medical insurance coverage in California, according to the 1989 National Health Interview Survey. 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, reported medical insurance coverage was moderate: 152/238 adults (64%) (79/130 women, 61%; 73/108 men, 68%; and 214/322 (66%) reported having public, private, combined public-private, or Mexican medical insurance plan at the time of the interview. It is important to point out that these totals- 152 and 214- count the few instances of combined public-private coverage as single policies. In the separate public and private coverage counts, however, the public-private coverage has been counted twice, once in each category. Thus, the accurate figure of 64% of adults covered appears to become 68% when the separated public (21%) and the private (47%) percentages are totaled.

Public Insurance

In this sample, 21% of adults (50/238), 23% of women (30/130) and 19% of men (20/108) had reported having some type of public medical insurance, compared to 39% of children (124/322). 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, but a few migrating farmworkers homebased in Arizona also qualified for Arizona's Medicaid program, Access, when living 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 not, they will receive expensive medical bills. Research findings show that knowledge of these available public programs is limited among this population.

Employee-Based Medical Insurance

In this sample, 111/238, 47% of the adults 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 (\$5,000), and restrictions on approved providers. Those with private insurance have many concerns and access issues that affected their overall use patterns.

Mexican Coverage and Mexican Medical Insurance

More than 80% 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 practitioners. Most of them paid out of pocket for services rendered. However, a small percentage of farmworkers went to Mexico for services because their U.S. employee-based private insurance covered 100% 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 included coverage for lab work and medicines.

The argument that immigrant farmworkers are burdening public hospitals with expensive and uncompensated care is not substantiated from the data collected.

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 8 illustrates the results.

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 farmworker households.

Potential Access to Medical Services

Potential access to medical services was examined by (1) analyzing knowledge of the geographic location of medical facilities, (2) uncovering medical programs targeted to low-income households, and (3) discovering 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 has some primary healthcare 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 proximity to these services.

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, cover urgent medical programs even for undocumented clients. A key question is, “to what extent do 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 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.

Figure 8. Chi-Square Analysis of Insurance & Migration

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

Furthermore, one female 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%), 35 of the 108 men (32%), and 108 of the 322 children under 18 (33.5%) 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% 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%), four of the 108 men (4%), and 17 of the 322 children under 18 (5.2%) utilized this restricted public medical insurance. In short, out of 560 farmworkers and their dependents, only 25 persons (4%) used this restricted, but often expensive, program for coverage of emergency medical expenses.

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. 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.

Realized Access to Medical Services

Realized healthcare access relates to the actual use of healthcare services to satisfy needs for healthcare 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 Farmworkers

Overall, the vast majority of both migrating and non-migrating farmworker households (approximately 90%) reported seeing a doctor when they are really sick. Even with no medical insurance, farmworkers 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 become 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. 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.

Medical Insurance Regulations and Medical Services

Realized healthcare access refers to the actual use of healthcare services to satisfy healthcare needs. Forces contributing to realized healthcare access could act 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 focused 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.

When heads of household were asked whether their family members faced difficulties in obtaining medical services, they cited the following as reasons they were sometimes prevented from seeking medical services: 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 or problems with their health insurance, and the long wait characteristic of most doctor's visits.

Denied Medical Attention

One important question asked of farmworkers was whether or not they were ever denied medical attention. More than 95% 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. 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 a hospital, but a doctor was there (Sept. 20, 1996)

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. Although 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 dental exams at school.

Realized Access and Public Insurance

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 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%... And he [her husband] has an appointment for the 26th of September. In this appointment they are going to take a camera and look inside (him). 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 still deny him Medi-Cal (September 1996).

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 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... They have told us that Medi-Cal is not going to be like the plan we already have. 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 is here in Mecca, and the clinic is closed, what are we going to do if we need to go see another doctor? It would be better if we could choose two doctors, but they say no more than one (March 1997).

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 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 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... 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. After all that, they said that we didn't qualify. I have not gone back to try to fill them because I have to ask for a ride... 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. 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: 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 Aug. 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 woman 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. 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% over there and only 80% 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?

Female Farmworker: She had the operation in March or April. And they operated on my nose.

Interviewer: Another operation? In Mexico?

Female Farmworker: In Mexico – because I had 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).

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% 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 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% of the farmworkers in this sample who receive employee-based private medical insurance. On the other hand, approximately 60% of the adults in this sample do not receive employer-based private medical insurance. Most farmworkers lose their Medi-Cal coverage when employment causes their income to rise. 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 healthcare 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 a problem as the forms are difficult, and migrating households typically don't have mail forwarded to their upstream residence.

Realized Access and Employee-Based 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.

Interviewer: You mentioned something about having to work a certain number of hours before you can use your medical insurance. Please explain...

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 1997, Spanish version in Appendix 2).

The farmworker profiled 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, 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... I not sure, I don't want to tell you lies. For crew leaders like us, they cover up to \$5,000, 100%. 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%. For the field laborers, they pay 80% 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% of the costs (September 1996).

This 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 \$5,000 twice without completing the sentence. It was later learned from other farmworkers that not only do farmworkers have a deductible to meet, but also they also usually have a \$5,000 per year cap on coverage. The next 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 insurance, but they are taking deductions from my check. That is why I said I bought this

insurance, they are not giving it to me. Every two weeks they take \$25 from my check for 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 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 (Sept. 19, 1996).

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. About 60% of the adults interviewed stated that they did not have any form of employee-based medical insurance. Many researchers 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.

As illustrated by the farmworkers' experiences, 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. 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. Coverage under private insurance offered by the growers usually does not take effect for several weeks. 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."

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% coverage if they obtained medical attention in the U.S.. 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 infeasible. 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 U.S.

As pointed out earlier, approximately 30% of the members of farmworker households reported having no medical insurance at the time of the interview. Usually this lack of medical insurance is 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?

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 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: Were you able to actually go to the unemployment office?

Female Farmworker: They ask for proof of income from work... 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 (Feb 1998).

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 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 multiple times.

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, even between states, poses special problems in terms of access to medical services. In California, if a farmworker household receiving some type of public assistance program migrates to another county, they 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 farmworker family member seeks care in a clinic while migrating and the medical insurance company office is closed, they 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 believe migrant farmworkers receive better services. Some farmworkers pointed out that some households migrate for the minimum amount of time allowed in order to qualify for Mecca's subsidized day-care programs. There are tensions between migrating and non-migrating farmworker households because of the scarcity of resources.

Finally, 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 are largely hidden from public view. The Immigration and Naturalization Service is 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 farmworker families 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 all farmworker households experience significant challenges that affect their well-being.

Summary

There are important distinctions between potential and realized healthcare access for both migrating and non-migrating farmworker households. Alan Dever, a researcher from the Mercer School of Medicine, found that farmworkers residing in "upstream" non-homebase areas could access more medical services than farmworkers living and working in homebase areas. In addition, Dever explicitly argues that, "access to healthcare 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).

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 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 healthcare access depends on a number of variables. In California, the most significant factors impacting both potential and realized healthcare access are type of medical insurance coverage, the stability of the work, and the possibility that a person can seek medical services in Mexico.

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; 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. These cases exemplify a high level of potential healthcare access and a low level of realized healthcare access.

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 delaying 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 Political Economy of Healthcare 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 national and international macro-level political and economic forces influence structural policies implemented locally.

Economy of Health and Access to Medical Services

This research project incorporates farmworkers' own accounts to understand constraints apparent in healthcare programs that target California farmworkers as well as other rural residents. Specific policy constraints inherent in various healthcare 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 potential and realized healthcare 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.

Policies Impacting Health Centers

The many levels of federal and state healthcare 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. 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. 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 continually entered, but seldom extracted for meaningful analysis. Medical schools, public health schools, schools of social science, and schools of computer science need 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 healthcare 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.

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 Newslines, 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 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 U.S. 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 in 1994, which made undocumented persons ineligible for public social services, public healthcare, 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 came 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 healthcare. 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 Aug. 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.

Local Structural Medical Insurance Barriers

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, they lack insurance, or they have not met their deductible.

Among those farmworkers 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 between counties when households migrate. Potential and realized access to care for non-life threatening emergencies and for tertiary or specialized care can be restricted by each county's interpretation of its legal responsibilities to persons covered by Medically Indigent Adults Program and/or Restrictive 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 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% (n = 98) of the farmworkers revealed that they were willing to pay for a monthly pre-paid health insurance plan that did not 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. The average amount that farmworkers were willing to pay for a consultation with a general practitioner was \$19. The average amount that farmworkers were willing to pay for a specialist was about \$36 and the average amount that farmworkers were willing to pay for an emergency visit was \$53. Finally, the average amount that farmworkers were willing to pay for laboratory work was approximately \$24. Considering that 38 households reported owing money for medical services obtained in the United States, with a minimum bill at \$25 and a maximum bill of \$10,700, these findings on ability to pay are important to consider in planning future types of public and privately-subsidized medical insurance programs.

Summary and Conclusions

Access to healthcare is understood as a social process determined by the characteristics of the healthcare 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 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

healthcare access under two labor patterns: when farmworkers migrate and when they do not. This research investigated how public, private, and charity health policy regulations affect access to medical care for farmworkers and their families. Cultural factors 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 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 differ based on the resources allocated to upstream and downstream locations. 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 were modern, included on site laundry, and were safe. Therefore, the research sample is biased towards more privileged farmworker families. Living closely among other farmworker families helps keep each other well informed about available services. Although a few household members were undocumented, most farmworkers in this sample qualified for some level of public services.

Policy Research Findings

As noted, this project focused 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 public and private healthcare coverage is greater for populations of resident, documented immigrants with stable living patterns. Population studied is atypical since many households sampled reside in subsidized government housing units where heads of

- households must prove 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 have 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 (39% of children, but only 21% 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 or specialized care can be restricted by each county's interpretation of legal responsibilities to families covered by Medically Indigent Adults and limited scope (restricted) Medi-Cal. Impacts all 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. Migrant households also need to re-apply in each county where they live and 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 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 wide ranges of private insurance programs are available in this unique farmworker population, the high deductibles, caps on coverage, and limitations on dependent coverage restrict the use of many 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, impacts the health and well being of the user and family members.

17. There are 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 healthcare policy reforms in California that could improve access to medical services among California farmworkers.

Recommendations

Overall, there needs to be improvements in the Medi-Cal application and eligibility process, and to fund and train community health workers to educate farmworkers on medical insurance programs. Committees should be established to examine bi-national medical insurance programs and to address public health issues of farmworkers living on Native American lands. There is also a 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.

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 routinely purged and discarded. Clients complete the same forms multiple times. The entire process needs to be simplified. Shortening 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 paperwork and the burden on clients; determine eligibility for Medi-Cal once a year. If clients migrate to other counties, their cases and eligibility should be transferred, too. Unless they do re-apply, most are ineligible for services in another county. The MIA and Medi-Cal should also be available statewide, 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. It would be more beneficial to increase their share of costs instead of eliminating their Medi-Cal eligibility.

Expanding the Denti-Cal program and providing additional funding for dental clinics in rural areas serving large concentrations of farmworkers are other options. Allocating additional funding for mental health services, including substance abuse treatment programs, in rural areas is an acceptable solution.

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. Streamlining the application process and making efforts to advertise these programs to the target population are recommended.

Fund and Train Community Health Workers

Farmworkers need a direct liaison between them, clinic providers, and other advocacy groups. Training community health workers to understand private and public medical insurance programs in California so they, in turn, can teach farmworkers and their family members is advisable. But training and adequately funding community workers in health education simply is not enough. If these types of programs were actually implemented, this intervention would have a profound impact on increasing farmworkers' utilization of healthcare services.

Examine Binational Insurance Practices

Binational efforts between Mexico and the United States need to be strengthened. Private U.S.-based medical insurance companies, such as Transwestern and Western Growers, pay 100% 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 U.S. medical insurance plans operate in Mexico. Private health foundations are beginning to develop this idea.

Establish Non-Government Committee

Dialog needs to be initiated 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 Native Americans, most are not eligible to use the nearby Indian Health Services. The public healthcare implications are enormous.

Provide Adequate Rural Medical Education Resources

Medical schools, public health schools, and schools of social science and 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.

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 healthcare clinic needs to be modified. Farmworkers need urgent care or ambulatory medical clinics in addition to preventative primary healthcare clinics. The very design of community clinics in isolated rural areas needs to be re-examined.

Consider Consumer-Friendly Service

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

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 1990's were characterized by an anti-immigrant sentiment, but 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 has become more complex and requires an increasingly sophisticated and educated work force that will continue to need a wide range of 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 largely determines whether or not these services will be used. Farmworkers and their families 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.

References

- Achata, C. 1993. "Immunization of Mexican Migrant Farm Worker's Children on Site at a Day Care Center in a Rural Tennessee County: Three Successful Summers" *Journal of Health and Social Policy* 4.
- Aday, L.A. 1974. "A Framework for the Study of Access to Medical Care." *Health Services Research*, 208-220.
- Akin, B.V., Lloyd Rucker, Allan Hubbell, Ralph Cygan and Howard Waitzkin. 1989. "Access to Medical Care in a Medically Indigent Population" *Journal of General Internal Medicine*, 4: 216-220.
- Altson, L.T.A., Benigno. 1987. "Elderly Mexican Americans: Nativity and Health Access" *International Migration Review*, 21 (3): 626-642.
- Alvarez, M. 1985. "Health Conditions of Mexican Women Immigrants – A Review of the Literature Border Health" *Salud Fronteriza*, 1 (No. 3): 48-52.
- Armelagos, G., Thomas Leatherman, Mary Ryan, Lynn Sibley. 1992. "Biocultural Synthesis in Medical Anthropology." *Medical Anthropology*, 14: 35-52.
- Ashabranner, B. 1985. *Dark Harvest Migrant Farmworkers in America*. N.Y., Dodd, Mead, and Company.
- Atkin, S.B. 1993. *Voices From The Fields*. Boston, Little, Brown, and Company.
- Azevedo, Kathryn and Hilda Ochoa Boyd. "Health and Occupational Risks of Latinos Living in Rural America." Book chapter to appear in edited book, *Health Issues in the Latino Community*, Jossey-Bass Publishers, Inc., San Francisco, April 2001.
- Azevedo, Kathryn, "Medical Insurance Coverage and Usage Among Farmworker Families: A Case Study," California Program on Access to Care, CPAC Brief: California Program on Access to Care, California Policy Research Center, University of California, Vol. 12, No 7, October 2000.
- Babbie, E. 1990. *Survey Research Methods*. Belmont, Wadsworth Publishing Company.
- Bade, Bonnie. 1999. "Is There a Doctor in the Field? Underlying Conditions Affecting Access to Health Care for California Farmworkers and their Families," published by the California Policy Research Center, California Program on Access to Care (CPAC) for the Conference on Expanding Health Care Access for California's Farmworkers held Sept. 16-17, 1999, Sacramento, Calif.
- Bade, Bonnie. 1993. "Problems surrounding health care service utilization for Mixtec migrant Latino agricultural workers in Madera, California." California Institute for Rural Studies, Davis, Calif.
- Barger, W.K., and Ernesto Reza. 1987. "Community Action and Social Adaptation: The Farmworker Movement in the Midwest" *Collaborative Research and Social Change*. Westview Press. 55-75.
- Barger, W.K., Ernesto M. Reza. 1994. *The Farm Labor Movement in the Midwest: Social Change and Adaptation among Migrant Farmworkers*. Austin, The University of Texas Press.
- Bashshur R.L., R.K. Homan, and D.G. Smith. 1994. "Beyond the Uninsured: Problems in Access to Care." *Medical Care*, May 1994, 32 (5): 409-19.
- Benavides-Vaello, S.H. Setler. 1994. "Working Paper No. 76 Migrant and Seasonal Farmworkers: Health Care Accessibility." University of Texas-Austin Lyndon B. Johnson School of Public Affairs.
- Bernard, Russell H. 1994. *Research Methods in Cultural Anthropology: Second Edition*, Sage Publications.
- Bingham, C.C., Ann. 1981. *Evaluation of the California Rural Health Services Development Program*. Sacramento, State of California.
- Bissell, K. 1976. *The Migrant Farmworker*. The Institute for Multidisciplinary Graduate Research.
- Bloom, A. 1985. "Introduction: The Client's Perspective in Primary Health Care." *Medical Anthropology*. (Winter 1985): 7-9.
- Boone, M.S. 1991. "Policy and Praxis in the 1990's: Anthropology and the Domestic Health Policy Arena." Training Manual in *Applied Medical Anthropology*. AAA. 23-55.
- Braden, J.K.B. 1994. *Health Status and Access to Care of Rural and Urban Populations*. Agency for Health Care Policy and Research.
- Braden, J.K.B. 1994. National Medical Expenditure Survey, Health Status and Access to Care of Rural and Urban Populations, Research Findings 18. U.S. Department of Health and Human Services.
- Browner, C.H., Bernard R. Ortiz de Montellano, Arthur Rubel. 1988. "A Methodology for Cross Cultural Ethnomedical Research." *Current Anthropology*. 29 (No 5, December, 1988): 681-702.

- California Legislature Budget Committee, Joint. 1981. Evaluation of the California Rural Health Services Development Program.
- Cancian, Francesca. 1993. "Conflicts Between Activist Research and Academic Success: Participatory Research and Alternative Strategies." *The American Sociologist*, Spring 1993: 92-105.
- Carlson, R.H. 1990. "Models for Increasing Access: Rejuvenating Community/Migrant Health Centers and the National Health Service Corps." *Journal of Health Care for the Poor and Underserved*. 1 (1): 116-125.
- Chavez, Leo. R. 1984. "Doctors, Curanderos and Brujas: Health Care Delivery and Mexican Immigrants in San Diego." *Medical Anthropology Quarterly*. 15: 31-37.
- Chavez, Leo. 1986. "Mexican Immigration and Health Care: A Political Economic Perspective." *Human Organization*. Vol. 45, No. 4 (Winter 1986): 344-349.
- Chavez, Leo. R., Wayne A. Cornelius, and Oliver William Jones. 1986. "Utilization of Health Services by Mexican Immigrant Women in San Diego." *Women and Health*. 11 (2): 3-19.
- Chavez, Leo. R. 1986. "Mexican Immigration and Health Care: A Political Economy Perspective." *Human Organization*, 45 (4): 344-352.
- Chavez, Leo, and Victor M. Torres. 1994. "The Political Economy of Latino Health." *Handbook of Hispanic Cultures in the United States: Anthropology*. 226-243.
- Chavez, L., Allan Hubbell, Juliet McMullin, Rebecca Martinez, and Shiraz Mishra. 1995. "Understanding Knowledge and Attitudes About Breast Cancer." *Archives of Family Medicine*, 4 (February): 145-152.
- Chi, P., and Janet McClain. 1992. "Drinking, Farm, and Camp Life: A Study of Drinking Behavior in Migrant Camps in New York State." *The Journal of Rural Health*, Winter 1992: 41-51.
- Ciesielski, S., Dana P. Loomis, Susan Rupp Mims, and Anella Auer. 1994. "Pesticide Exposures, Cholinesterase Depression and Symptoms among North Carolina Migrant Farmworkers." *American Journal of Public Health*, 84 (3): 446-451.
- Commission, on Security and Cooperation in Europe. 1993. *Implementation of the Helsinki Accords: Migrant Farmworkers in the United States*. Washington, D.C., U.S. Government Printing Office.
- Congress, United States. 1982. Public Health Service Legislation.
- Congress, United States. 1982. Public Health Service Section 329.
- Council, F.W.S.C. 1994. Farm Worker Services Coordinating Council. "A Status Report, Improving Services for California's Farm Worker Community." Health and Welfare Agency.
- Council, C.F.W.S.C. 1994. *The California Farm Worker Services Directory*. State of California Health and Welfare Agency.
- Daniel, C.E. 1982. *Bitter Harvest, A History of California Farmworkers 1870-1941*. Berkeley, University of California Press.
- de la Torre, A.R., Lynda. 1987. "The Determinants of Breast feeding for Mexican Migrant Women." *International Migration Review*, 21 (3): 728-742.
- Dement, E.F. 1985. "Out of Sight, Out of Mind: An Update on Migrant Farmworker Issues in Today's Agricultural Labor Market." Washington, D.C., National Governors' Association.
- Dever, Alan. 1993. "Migrant Health Status: Profile of a Population With Complex Health Problems." Migrant Clinicians Network. Monograph Series.
- Donahue, J.M. 1989. "Rural Health Efforts in the Urban-Dominated Political Economy: Three Third World Examples." *Medical Anthropology*, Vol. 11: 109-125.
- Dorsey, L.C. 1991. "The Rural Child." *Journal of Health Care for the Poor and Underserved*, 2 (1): 76-86.
- Ehrenreich, J. 1978. Introduction. *Cultural Crisis of Modern Medicine*. New York, Monthly Review Press.
- Evans, J. 1987. "Migration and Health" *International Migration Review*, xxi (No 3.): v-xiv.
- Foulkes, Cecilia. 1985. *Mecca: A California Desert History*. Published by Cecilia Foulkes.
- Galarza, Ernesto. 1964. *Merchants of Labor – The Mexican Bracero Story*. Charlotte/Santa Barbara, McNally/Loftin.
- Gamsky, T., Stephen McCurdy, Patricia Wiggins, Steven Samuels, Brian Berman, and Marc Shenker. 1992. "Epidemiology of Dermatitis among California Farm Workers." *Journal of Occupational Medicine*, 34 (No. 3).
- Gardner, R.J. 1993. "National Health Care Reform and Community Migrant Health Centers." *Journal of Health Care for Poor and Underserved*, 4: 268-271.

- Grey, M. 1993. "Dustbowls, Disease, and the New Deal: The Farm Security Administration Migrant Health Programs, 1935-1947." *Journal of History of Medicine and Allied Sciences*, 48: 3-39.
- Griffith, D.E. Kissam. 1995. *Working Poor Farmworkers in the United States*. Philadelphia, Temple Univ. Press.
- Guendelman, S., Auristela. 1987. "Migration Tradeoffs: Men's Experiences with Seasonal Lifestyles." *International Migration Review*, 21 (3): 709-727.
- Guendelman, S. 1991. "Health Care Users Residing on the Mexican Border." *Medical Care*, 29 (5): 419-427.
- Hall, B.F.R. 1994. Report, Health Data Summaries for California Counties. Department of Health Services, State of California.
- Harrington, Michael. 1969. *The Other America: Poverty in the United States*.
- Hartley, D., Lois Quam, and Nicole Lurie. 1994. "Urban and Rural Differences in Health Insurance and Access to Care." *The Journal of Rural Health*, 10: 98-108.
- Harthorn, Barbara Herr. 1998. "California Farmworkers: Dilemmas in Developing Interventions for Health and Medical Concerns." *Human Organization*, Vol. 57, No. 3, Fall 1998: 369-378.
- Hayes-Bautista, D.E., Baezconde-Garbanati, Lourdes, Schink, Werner O., and Maria Hayes-Bautista. 1994. "Latino Health in California, 1985-1990: Implications for Family Practice." *Family Medicine*, 26: 556-562.
- Healthy People 2000: National Health Promotion and Disease Prevention Objectives. 1990. U.S. Department of Health and Human Services Public Health Service.
- Hewitt, M. 1989. Defining "Rural" Areas: Impact on Health Care Policy and Research. Congress of the United States.
- Hubbell, A., Howard Waitzkin, Shiraz Mishra, John Dombrink, Leo Chavez. 1991. "Access to Medical Care for Documented and Undocumented Latinos in a Southern California County." *Western Journal of Medicine*, 154: 414-417.
- Inhorn, M.C. 1995. "Medical Anthropology and Epidemiology: Divergences or Convergences?" *Social Science and Medicine*, 40 (3): 285-290.
- Johnston, H.E. 1985. *Health for the Nation's Harvesters*. Farmington Hills, Mich., National Migrant Worker Council, Inc.
- Jones, J.L., Pamela Rion, Shirley Hollis, Sharon Longshore, William B. Leverette, and Lori Ziff. 1991. "HIV-Related Characteristics of Migrant Workers in Rural South Carolina." *Southern Medical Journal*, 84 (9): 1088-1090.
- Kearney, M.A.M., Richard. 1987. *Migration and Farmworker Health in the Central Valley of California*. American Anthropological Association.
- Kerr, M., and Deborah A Ritchey. 1990. "Health-Promoting Lifestyles of English-Speaking and Spanish-Speaking Mexican-American Migrant Farm Workers." *Public Health Nursing*, 7 (No. 2): 80-97.
- Khan, A.A. Bhardwaj., Surinder M. (1994). "Access to Health Care: A Conceptual Framework and its Relevance to Health Care Planning." *Evaluation and the Health Professions*, 17 (1): 60-76.
- Koos, E.L. 1957. "They Follow the Sun." Jacksonville Bureau of Maternal and Child Health, Florida State Board of Health.
- Krieger, R., C. Blewett, S. Edminston, H. Fong, D. Gibbons, D. Meinders, L. O'Connell, F. Schneider, J. Spencer, and T. Thongsinthusak. 1990. "Gauging Pesticide Exposure of Handlers (Mixers/ Loaders/Applicators) and Harvester's in California Agriculture." *La Medicina del Lavaro*, 81 (6).
- Laflin, Patricia. 1998. *Coachella Valley History: A Pictorial History*. The Donning Company Publishers.
- Larson, K., Joan McGuire, Elizabeth Watkins, and Karen Mountain. 1992. "Maternal Care Coordination for Migrant Farmworker Women: Program Structure and Evaluation of Effects on Use of Prenatal Care and Birth Outcome." *Journal of Rural Health*, 8: 128-133.
- Larson, A.C., A.L. Plascencia. 1993. *Migrant Enumeration Project*. Migrant Legal Services.
- Lepkowski, J.M. 1991. "Sampling the Difficult to Sample." *American Institute of Nutrition*, 121: 416.
- Lewis, C.E. 1977. Improved Access through Regionalization. Regionalization and Health Policy. In Ginzburg (Ed.). Washington, D.C., U.S. Department of Health, Education and Welfare Publication HRA 77-623: 71-84.
- Littlefield, C. 1987. "A Survey of Colorado's Migrant Farmworkers: Access to Health Care." *International Migration Review*, xxi (No. 3): 688- 708.
- Maguire, M.J. 1972. *The Health and Developmental Status of the Infant in Migrant Farmworker Families*. University of California-Davis.

- Margolis, R.J. 1981. "Homes of the Brave: A Report on Migrant Farmworker Housing." Washington, D.C., *Rural America*.
- Martin, M., D.A. Martin. 1994. *The Endless Quest: Helping America's Farm Workers*. Boulder, Colo., Westview Press.
- McGreevy, J. 1993. "Caring for the Health and Culture of Migrant Workers." *Pennsylvania Medicine*, 16-17.
- McKay, E.G. 1982. *Summary Analysis of Farmworker Populations Including Population Estimates and Relationship to Allocation of Migrant Youth Employment Funds*. Washington, D.C., National Council La Raza.
- Mechanic, D. 1974. "Politics, Social Science, and Health Policy in the United States." *Politics, Medicine, and Social Science*. New York, Wiley-Interscience Publication, 47-57.
- Mechanic, D. 1993. "Social Research in Health and the American Sociopolitical Context: The Changing of Fortunes of Medical Sociology." *Social Science and Medicine*, 36 (No. 2): 95-102.
- Medi-Cal Policy Institute. 1999. *Medi-Cal County Data Book*. Medi-Cal Policy Institute, Oakland, Calif.
- Medi-Cal Policy Institute. 1999. *Understanding Medi-Cal: Basics*. Medi-Cal Policy Institute, Oakland, Calif.
- "Medicare and Medicaid Provisions: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 H.R. 3734 and Health Insurance Portability and Accountability Act of 1996 H.R. 3103." 1996. *Medicare and Medicaid Guide* (918 Extra Issue).
- Mehler, L.N., Michael A. O'Malley, and Robert I. Krieger. 1992. "Acute Pesticide Morbidity and Mortality: California." *Reviews of Environmental Contamination and Toxicology*. New York, Springer-Verlag, 51-66.
- Merrill, M. 1960. *Health Conditions and Services for Domestic Seasonal Agricultural Workers and Their Families in California*. California State Department of Public Health.
- MEXUS, U. 1995. *Latinos in California*. Report of Activities Funded by the University of California Committee on Latino Research. University of California.
- Migrant Health Centers Referral Directory*. 1994. Austin, Texas, National Migrant Resource Program.
- Migrant Health Centers Referral Directory*. 1998. Austin, Texas, National Migrant Resource Program.
- Mines, R. and Michael Kearney. 1982. *The Health of Tulare County Farmworkers*. State of California, Department of Health Services.
- Moore, ed. 1980. "Cultural belief systems and their impact on health care." *The Biocultural Basis of Health: Expanding Views of Medical Anthropology*. Prospect Heights, Ill., Waveland Press, Inc.
- Moore, P. D., Lorna Grindlay, Peter W. Van Arsdale, JoAnn E. Glittenberg, and Robert A. Aldrich, Ed. 1980. *The Biocultural Basis of Health: Expanding Views of Medical Anthropology*. Prospect Heights, Ill., Waveland Press, Inc.
- Morgan, Lynn M. 1987. "Dependency Theory in the Political Economy of Health: An Anthropological Critique." *Medical Anthropology Quarterly*, New Series/Volume 1/Number 2/June 1987 (Number 2/June 1987): 131-154.
- National Immigration Law Center. 1995. "Summary of Immigration Provisions of the Personal Responsibility Act (PRA)." National Immigration Law Center.
- National Migrant Resource Program. 1992. Proceedings of the Migrant Stream Forums. Portland Ore., South Padre Island, Texas, and Philadelphia, Pa.
- Oliveira, V.J.L.A.W. 1993. *Improving Living and Working Conditions of Hired Farmworkers*. USDA.
- Osorio, A.M., Richard G. Ames, Jon Rosenberg, and Donald C. Mengle. 1991. "Investigations of a Fatality Among Parathion Applicators in California." *American Journal of Industrial Medicine*, 20: 533-546.
- Palerm, Juan Vicente. 1991. *Farm Labor Needs and Farm Workers in Calif. State Employment Development Dept.*
- Palerm, Juan Vicente. 1992. "Cross-cultural Medicine a Decade Later: A Season in the Life of a Migrant Farm Worker in California." *The Western Journal of Medicine*, 157 (3): 362-366.
- Palerm, Juan Vicente, 1993. "A Binational System of Agricultural Production: The Case of the Mexican Bajo and California." *Mexico and the United States Neighbors in Crisis*. The Borgo Press.
- Palerm, Juan Vicente. 1994. "Immigrant and Migrant Farm Workers in the Santa Maria Valley, California." Center for Survey Research Methods Research.
- Palerm, Juan Vicente. 1995. *Policy Implications of Community Studies. Changing Face of Rural California*. Pacific Grove, California, University of California-Riverside.
- Pelto, P.J. 1978. "Medicine, Anthropology, Community: An Overview." *Health and The Human Condition*. Duxbury Press, 401-406.
- Penchansky, R. and J.W. Thomas. 1981. "The Concept of Access." *Medical Care*, 19: 127-140.

- Quandt, Sara, Thomas Arcury, Colin Austin, and Rosa Saavedra. 1998. "Farmworkers and Farmer Perceptions of Farmworker Agricultural Chemical Exposure in North Carolina." *Human Organization*, Vol. 57, No 3: 359-368.
- RCAP/MESA. 1995. *The 1995 RCAP/MESA Calendar*. Rural Community Assistance Program.
- Reza, B.W. 1989. "Policy and Community-Action Research: the Farm Labor Movement in California." *Making Our Research Useful: Case Studies in the Utilization of Anthropological Knowledge*. Westview Press, 257-282.
- Riessman, C.K. 1993. *Narrative Analysis: Qualitative Research Methods*. Newbury Park, Sage Publications.
- Rodriguez, R. 1993. "Violence in Transience: Nursing Care of Battered Migrant Women." *AWHONN's Clinical Issues*, 4: 437-441.
- Rosenbaum, S., and Julie Darnell. 1996. Preliminary Report: An Analysis of the Medicaid and Health Related Provisions of the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996." Center for Health Policy Research.
- Rosenberg, Howard, Anne Stierman, Susan Gabbard, and Richard Mines. "Who Works on California Farms: Demographic and Employment Findings from the National Agricultural Workers Survey." Agricultural and Natural Resources Publication, 21583, Agricultural Personnel Management Program, University of California, 1998.
- Ruducha, J. 1989. *Determinants of Health Status and Use of Health Services by Migrant Children*. Johns Hopkins University.
- Rumbaut, R.G., Leo R. Chavez, Robert R. Moser, Sheila M. Pickwell, and Samuel M. Wishik. 1988. "The Politics of Migrant Health Care: A Comparative Study of Mexican Immigrants and Indochinese Refugees." *Research in the Sociology of Health Care*, JAI Press, 143-202.
- Runyan, Jack. "A Profile of Hired Farmworkers, 1992 Annual Averages." United States Department of Agriculture, Economic Research Service, Agricultural Economic Report Number 693, July 1994.
- Rust, G. 1990. "Health Status of Migrant Farmworkers: A Literature Review and Commentary." *American Journal of Public Health*, 80 (10): 1213-1217.
- Sakala, C. 1987. "Migrant and Seasonal Farmworkers in the United States: A Review of Health Hazards, Status, and Policy." *International Migration Review*, xxi (3): 659-687.
- Scheder, J.C. 1988. "A Sickly-Sweet Harvest: Farmworker Diabetes and Social Equality." *Medical Anthropology Quarterly*, 2 (3): 251-277.
- Shenkin, B.N. 1974. *Health and Migrant Workers: Policies and Politics*. Cambridge, Ballinger Company.
- Shi, L., Michael Samuels, Thomas Konrad, Thomas Ricketts, Carleen Stoskopf, and Donna Richter. 1993. "The Determinants of Utilization of Non-physician Providers in Rural Community and Migrant Health Centers." *The Journal of Rural Health*: 27-39.
- Sills, E., Jeffrey Alwang, and Paul Driscoll. 1993. *The Economic Impact of Migrant Farmworkers on VA's Eastern Shore*. Virginia Tech, College of Agriculture and Life Sciences.
- Singer, Merrill. 1989. "The Limitations of Medical Ecology: The Concept of Adaptation in the Context of Social Stratification and Social Transformation." *Medical Anthropology*, Vol. 10: 223-234.
- Singer, Merrill. 1990. "Postmodernism and Medical Anthropology: Words of Caution." *Medical Anthropology*, 12: 289-304.
- Singer, Merrill. 1994. "AIDS and the Health Crisis of the U.S. Urban Poor: The Perspective of Critical Medical Anthropology." *Medical Anthropology*, 39: 931-948.
- Slesinger, Dorothy P. 1979. *Health Care Needs of Migrant Workers in Wisconsin*. University of Wisconsin.
- Slesinger, Dorothy P. 1992. "Health Status and Needs of Migrant Farm Workers in the United States: A Literature Review." *Journal of Rural Health*, 8 (3): 227-234.
- Slesinger, Dorothy P. 1993. "Economic and Health Needs of Wisconsin Migrant Farm Workers." *Journal of Rural Health*, 9 (2): 138-147.
- Smoley, S.R. 1994. *Improving Services for California's Farm Worker Community*. Sacramento. State of California Health and Welfare Agency.
- State Action on Immigrant Food Assistance. 1999. Newsletter.
- State of California. 1998. *Health Families Application Certification Training Manual*.
- State of California. 1994. *California Guide for Farmworkers*. Employment Development Department.
- State of California. 1988. *Migrant Farmworker Housing in California*. Sacramento, Department of Housing and Community Development.

- Super, D.A., Sharon Parrott, Susan Steinmetz, and Cindy Mann. 1996. *The New Welfare Law*. Center of Budget and Policy Priorities.
- Terry, J.L. 1988. *The Political Economy of Migrant Farm Labor and the Farmworker Movement in the Midwest*. Purdue University.
- Torres, V. 1993. *The Cultural Construction of Pregnancy and Reproductive Health Seeking Behavior on the Frontier: The Case of Maquiladora Women in Tijuana, Mexico*. University of California.
- Treviño, R., Fernando Treviño, Rolando Medina, Gilbert Ramirez, and Robert Ramirez. 1996. "Health Care Access Among Mexican Americans With Different Health Insurance Coverage." *Journal of Health Care for the Poor and Underserved*, 7 (2): 112-121.
- U.S. Department of Health and Human Services. 1990. *An ATLAS of State Profiles Which Estimate Number of Migrant and Seasonal Farmworkers and Members of Their Families*. Migrant Health Program. Washington, D.C.
- U.S. Department of Health and Human Services. 1996. *Models That Work: The 1996 Compendium of Innovative Primary Health Care Programs for Underserved and Vulnerable Populations*. Washington, D.C.
- U.S. Government, General Accounting Office. 1992. *Hired Farmworkers at Risk*.
- Van Wagenen, R. Keith. 1991. *Writing a Thesis: Substance and Style*. Prentice Hall, New Jersey.
- Vaughan, Elaine. 1993. "Chronic Exposure to an Environmental Hazard: Risk Perceptions and Self-Protective Behavior." *Health Psychology*, 12 (1).
- Vega, W.A., Kolody, Bohdan and Valle, Juan Ramon. 1987. "Migration and Mental Health: An Empirical Test of Depression Risk Factors Among Immigrant Mexican Women." *International Migration Review*, 21 (3): 512-529.
- Villarejo, Don, et. al. 2000. A Report from The California Endowment, "Suffering in Silence: A Report on the Health of California's Agricultural Workers.
- Villarejo, Don. 1999. "Health Care Status to Health Care Among California's Hired Farm Workers." California Institute for Rural Studies, Inc.
- Voelker, David and Orton. 1993. *Statistics: Cliffs Quick Review*. Cliff Notes Incorporated, Lincoln, Neb.
- Walton, R.M.V. 1940. *A Study of Migratory Mexican Pea-Pickers in Imperial Valley*. University of Southern California.
- Washington Newsline. 1996. Association of Farmworker Opportunity Programs.
- Watkins, E., Kim Larson, Christina Harlan, and Suzanna Young. 1990. "A Model Program for Providing Health Services for Migrant Farmworker Mothers and Children." *Public Health Reports*, 105 (6): 567-575.
- "Welfare Reform Bill Restricts Medicaid Coverage for Immigrants." 1996. *Medicare and Medicaid Guide* (918 Part 1): 1-11.
- Wells, Miriam J. *Strawberry Fields: Politics, Class, and Work in California Agriculture*. Cornell University Press, 1996.
- Whiteford, L.M. 1991. "Need Assessment and Program Evaluation in Community Health." Training Manual in *Applied Medical Anthropology*. AAA, 101-124.
- Wilt, Valerie A. 1993. "Health Hazards to Children in Agriculture." *American Journal of Industrial Medicine*, 24: 283-290.
- Wilt, Valerie A. 1986. *The Occupational Health Of Migrant and Seasonal Farmworkers in the United States*. Farmworker Justice Fund.
- Wyn, Roberta E., Richard Brown, R. Burciaga Valdez, Hongjian Yu, William Cumberland, Hal Morgenstern, Chris Hafner-Eaton, and Chao Wang. 1993. "Health Insurance Coverage of California's Latino Population and Their Use of Health Services." A Report to the Latina/Latino Policy Research Program, University of California, 1993.

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 your civil status?

____ soltero/a (single) ____ casado/a (married) ____ viudo/a/(widowed)
____ divorciado/a ____ separado/a/(separated) ____ arrojuntado/union libre

4. Dígame solamente su nombre, no necesita decirme su apellido. 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 compañero? _____
¿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 considerará 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, folieto, cuentas)?
 * If you have information about your insurance, can I see it? such as a card, a pamphlet, 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 ocurrido 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 experiencias 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 of your family solicited medical attention? México__ US
____ 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? 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 calificaría 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? _____

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 ocurrido 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 experiencias con servicios médicos.
In this part I ask you about your medical experiences.**

23. ¿Cuándo fue la última vez que solicitó atención médica para usted o para su familia? ¿Dónde?
Where was the last time that you or a member of your family solicited medical attention? México ___ US
___ 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? How did they treat you?
Excelente ___ Muy buena ___ Buena ___ Regular ___ Mala _____
¿Cuánto pagó? _____ México ___ US _____

24. ¿Cuándo fue la última 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 calificaría 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? _____

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 después 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 están 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 están 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 están viajando por el campo? departamento _____

labor camp/campo de trabajo _____ temporary migrant family project/

proyecto 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 están 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? Si 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 atención 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 clínica cuando uno está enfermo? ___ en la mañana ___ en la tarde ___ en la noche ___
Lunes ___ Martes ___ Miércoles ___ Jueves ___ Viernes ___ Sábado ___ Domingo ___

49. ¿Qué tipos de médicos quiere usted ver más en una clínica? médico familiar ___ pediatra ___
médico 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? Si ___ 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 inmigrantes.

61. ¿Usted sabe que ahora hay nuevas leyes que afectan a los inmigrantes? 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 Progreso, 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 población.

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.

MEDICAL CONDITIONS REPORTED

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 cerca 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, dejó 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 esprayen 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 así 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 insoportable, 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 cochinerero 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 cochinerero.

Male Farmworker: Pero sigo trabajando allí.

September 18, 1996 page 104

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 están emigrando por el campo sabe dónde están las clínicas de salud en la comunidad?

Female Farmworker: No

Interviewer: ¿Y sabe dónde está 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 está viviendo arriba tiene usted problemas con transportación cuando un miembro de la familia necesita ir al doctor?

Female Farmworker: Sí, porque sí.

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 frío. 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

TRADITIONAL MEDICAL PRACTICES

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 truenan. 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 truenan. De acá te los truenan 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?

REALIZED ACCESS AND PUBLIC INSURANCE

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 tenemos 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 tenemos que nos cambien por otras Medi-Cales como le digo esa ProCare y eso tenemos 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 paquete, 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 seguridad y allá se cubre todo. Nomás nos mandan un papel de lo que pago la seguridad 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 explicame 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 seguridad.

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 seguridad...

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 seguridad?

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 seguridad, o sea no la compre, me ofrecieron una seguridad aquí en mi trabajo que me estaban rebajando del cheque por eso digo que compre la seguridad, 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 seguridad que le ofrecen?

Female Farmworker: No sé, aquí tengo la tarjetita.

Interviewer: ¿La seguridad 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