



Pathways to Farmworker Health Care

Case Study No. 1: The East Coachella Valley

Research conducted by



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The California Endowment

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A baseline report of the
Agricultural Worker Health Initiative



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EXECUTIVE SUMMARY

This is the first in a series of Agricultural Worker Health Studies (AWHS) sponsored by The California Endowment. This case study focuses on the East Coachella Valley (ECV), one of 10 agricultural subregions identified in the state.¹ The intention of this and subsequent studies in the series is to provide a subregional baseline assessment of farmworker health and health care. The assessments focus on evaluating farmworker living and working conditions and examine the channels and barriers to service delivery that exist within and outside the subregion. The studies also include options for a community-based intervention strategy, which are intended to help guide The California Endowment's Agriculture Worker Health Initiative.

The case-study design being used in the AWHS follows a multimodal approach. It relies on the qualitative techniques of documentary review, participatory observation, and telephone and in-person interviews with representatives of service providers, politicians, housing specialists, hunger workers, and, most importantly, with the farmworkers themselves. The aim is to try and marshal many sources of information to converge on and flesh out the full story.

FINDINGS

Living and Working Conditions

- Farmworker living conditions in some areas of the ECV are unhealthful due to contaminated drinking water and exposure to carcinogens and other pollutants. New farmworker housing stock intended to improve existing conditions is cur-

rently under construction.

- Most existing farmworker housing is located in remote areas and is widely dispersed. Public transportation is virtually nonexistent in these areas, which makes it difficult for workers to travel to a health care center when needed. Compounding this problem are INS roadblocks, which curtail farmworker movements in the region and instill fear in the population of U.S. institutions.

Treatment of Medical Conditions

- Numerous respondents reported experiencing depression, sadness, or abuse; however, none reported going to a counselor. Mental health professionals confirmed that there is little counseling carried out among the population. Few Spanish-speaking counselors are available in the ECV.

- Despite widespread chronic health conditions, including diabetes, asthma, hypertension, and cancer, the ECV farmworker population does not receive continuous care, resulting in many crisis interventions.

- ECV farmworkers suffer from chronic back pain and other musculoskeletal pain. Most reported difficulties in obtaining associated compensation for time off work and full medical coverage. For this reason, many farmworkers do not report their injuries and instead attempt to treat them on their own, seek treatment in Mexicali, or leave injuries entirely untreated.

Health Care Delivery System

- Many practitioners in the ECV do not speak Spanish, resulting in a language

barrier that creates obstacles and inefficiencies in treating patients. According to some providers, the problem of treating the farmworker population involves a deeper cultural sensitivity, rather than simply surmounting a language barrier.

- Farmworkers lack basic knowledge of formal health care institutions and the ways they can utilize services. A majority are not aware of services available at lower-cost clinics in the Coachella area, nor are they aware of social service programs for which they might be qualified.
- Farmworkers perceive health care services paid for in cash as better than those received through assistance programs. Yet many do not have the cash needed to pay.
- Most ECV workers reported having no health insurance. Those that did report having employer insurance paid a high premium.
- Many ECV farmworkers obtained health care outside of the region, often in the Mexican town of Mexicali. The associated time and distance delay involved in traveling outside the region hampers the delivery of effective services. Another problem is that the local ECV clinics are overcrowded and have long wait times.
- Farmworkers in the ECV are rarely successfully referred to specialists for needed care. The treatment received by pregnant women in the ECV stands out as an exception. The reason is that the clinics and specialists understand that Medi-Cal will cover payments for these individuals.
- It is difficult for a physician to make as good a living in the ECV compared to the affluent West Valley. ECV providers thus

struggle to retain talented staff. Some practitioners in the area also expressed feelings of being isolated and desired a more robust professional network.

- Some ECV clinics collaborate well with each other, but others suffer under strained relationships and competition. On the binational level, collaboration is limited.

COMMUNITY-BASED INTERVENTION OPTIONS

1. SUPPORT FOR ONE-STOP HEALTH SERVICE CENTERS

Our centerpiece intervention is to catalyze existing interest in developing one-stop health service centers. This is an intervention highly favored among service and health professionals in the region and among the farmworker community. There is a need to ensure that associated support services are available at these centers. These services include: transportation, culturally sensitive specialist care, child care, expanded use of *promotoras*, urgent care, health education, and ESL training.

2. UPGRADE HOUSING AND LIVING CONDITIONS

The existing county housing loan program should be expanded to include residences on tribal lands. In addition, local tribes need resources to develop appropriate housing ordinances and additional engineering services are needed.

3. SUPPLEMENTARY INTERVENTIONS

Several additional measures are suggested that range from providing mobile mental health services to facilitating binational cooperation among U.S. and Mexican practitioners.

BACKGROUND

The ECV has a large and growing farmworker population.² The area includes the “Triangle,” an isolated region comprised of the unincorporated areas of Mecca, Oasis, and Thermal. It also includes the surrounding towns of Coachella, Desert Shores, and North Shore.

The region is flanked to the west by the affluent recreational communities of Palm Desert and Palm Springs, to the north and east by the desert of Joshua Tree National Park, and to the south by the Salton Sea and, further south, the Imperial Valley.

The ECV is a heavily agricultural area specializing in table grapes, vegetables, citrus, and dates. Farms in the area developed slowly at the beginning of the last century. Until 1947, the region was dependent on well water, which was relatively ample but only supported 15,000 acres of crops. After the Coachella Branch of the All-American Canal was brought into operation, channeling Colorado River water to the valley, agriculture was greatly expanded. In 1997, almost 60,000 acres were under production.

ENVIRONMENT

The Coachella Valley is extremely hot and arid. Its elevation varies from over 400 feet in Palm Springs to less than 200 feet below sea level in the eastern section. It receives only three inches of rain per year, but it is still subject to dangerous flash floods. The valley also experiences extreme heat and relatively cold periods—temperatures can reach 120 degrees in the summer but there are also occasional freezes in the winter. These variable conditions impact residents of the ECV in different ways, for example,

through frequent power outages. Similarly, expensive power rates make it difficult for many residents to properly cool or heat their poorly insulated homes.

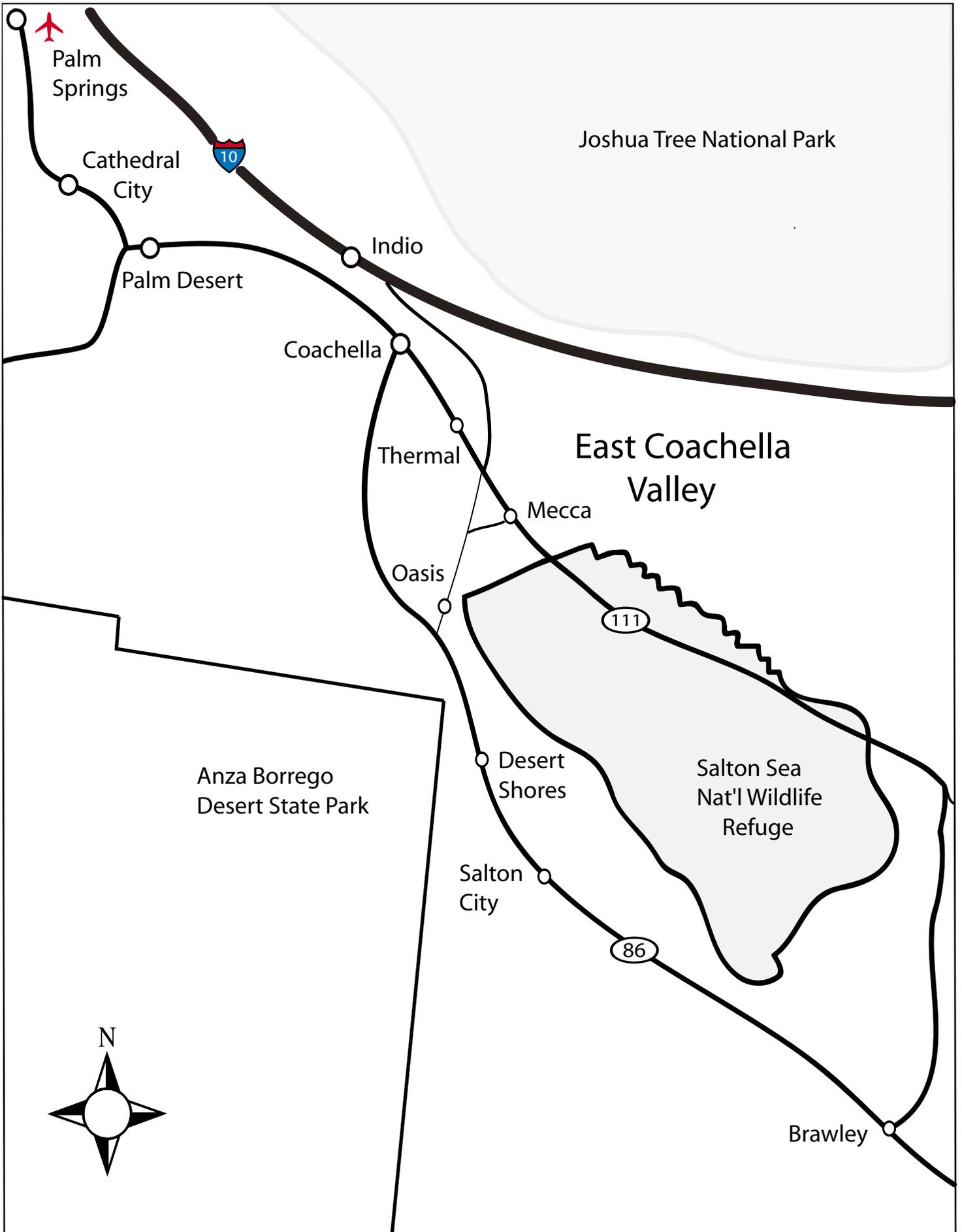
The potential for serious environmental problems also exists, particularly if planned cutbacks in water delivery (resulting from Colorado River diversions to San Diego) are implemented, reducing the water flowing to the Salton Sea. Many fear that if much of the sea bed subsequently becomes exposed, then the farmworker population that lives in the vicinity will be vulnerable to dust storms contaminated with chemicals that have accumulated in the Salton Sea for years via agricultural runoff.

DEMOGRAPHIC PATTERNS

The Census has reported per capita incomes in the region below \$7,000.³ Yet these figures do not reflect the true poverty of the residents, as the Census tends to systematically undercount the farmworker population. Workers who are undocumented, mobile, and those who live in unconventional or isolated circumstances are routinely missed by the Census, relative to the more stable and established part of the population. The undercount is conservatively estimated to be 50 percent too low.⁴ Since the Census is known to miss many of the poorest residents, it is certain that income levels in the ECV reach far below \$7,000 per capita.⁵

Age, Family Size, Marital Status, and Ethnicity

Despite its limitations, the Census information reveals certain demographic patterns within the ECV in comparison to other parts of the Coachella Valley and state. First, few people live alone (less than 5



percent compared to 24 percent statewide). The average family size is very high (5.2 in Mecca compared to 2.9 statewide). The population is also quite young on average (median age in Mecca is 22 compared to 33 statewide), and less than 5 percent of individuals are more than 65 years of age compared to 10 percent for the same category statewide. There are very high percentages of married couples (68 percent of the households in Mecca compared to 51 percent statewide), but there are also many solo males (43 percent in Mecca compared to 50 percent statewide).⁶ Over 95 percent of the residents of the area are Hispanic.⁷

Population and Employment Trends

Due to the Census's tendency to undercount farmworkers, it is difficult to estimate the area's true population. For example, the count for Mecca was approximately 1,966 for the 1990 Census but 5,402 for the 2000 Census. Such volatile numbers are highly unreliable. The populations of Mecca, Oasis, and Thermal are each likely to be at least 7,000, for a minimum overall population of 21,000. However, during the table grape season peak in May and June, the population may increase by another 5,000–10,000 temporary workers.⁸ The vineyard, tree, and row crop industries (covering 60,000 acres) employ at least 20,000 workers at peak season.⁹

The farmworker communities also include many former farmworkers who now work in the service trades supporting the Coachella Valley's large recreational industry (many farmworker families have one or more members working outside of agriculture). Most of the adult residents of the Triangle area have labored in the fields for part of their working life.

Finally, there is growing competition from Chile and Mexico for the table grape industry's spring window, which the Coachella Valley had enjoyed for many years. In 1995, there were 16,000 acres of table grapes grown in the valley, compared to 12,000 in the year 2000. This decline represents a decrease in employment possibilities, which may impact the population's income and ability to afford medical care.

ANALYSIS OF KEY DIMENSIONS

PART I: LIVING AND WORKING CONDITIONS

Working conditions in the ECV are contributing to a high incidence of debilitating health conditions among farmworkers. Matched with meager, stressful, and dangerous housing, these conditions impose substantial health risks for workers. Fortunately, the situation is not entirely hopeless, and a number of new initiatives are underway that seek to improve existing conditions.

Farmworker Housing

In the Triangle, there is a combination of mobile homes and permanent or "stick-built" houses.¹⁰ The unincorporated area of Mecca has the largest concentration of stick-built houses, and there are other much smaller groups of such houses in Thermal and Oasis. The mobile home parks are mostly small in size (less than 12 units per park) and are randomly dispersed throughout the Triangle. This dispersion tends to isolate the parks from one another and creates transportation hurdles that, in turn, impact farmworker access to health care. Public transportation from the parks to more populated areas, such as Coachella, is

virtually nonexistent. Women and children are particularly affected, as they generally remain in the parks while male workers take family automobiles to job sites during the day. The need to group people into more cohesive settlements, however, implies the need to construct centralized sewage and water systems.

As will be discussed below, local officials are aware of these problems and have been taking steps to ameliorate them. Other groups have also been active. For example, one neighborhood group, the 62nd Avenue organization, is meeting regularly with an engineer to discuss how to begin upgrading facilities in their area. The housing stock in Mecca has also been improved by the energetic intervention of the Coachella Valley Housing Coalition (CVHC), plus direct support from county resources. Apartments with family housing (including Mecca II and Nuestra Vista) as well as apartments shared by unrelated (mostly male) farmworkers have been built by the CVHC. In addition, the CVHC is building a trailer park in Mecca with more than 100 units. There have been at least 500 units built over the last decade in the area by the county and CVHC.¹¹

Marginal Mobile Homes

The majority of all structures in the Triangle are mobile homes or trailers. According to the County Economic Development Administration (EDA), there are at least 307 mobile home parks in the area, with approximately 10 to 15 families in each park. Assuming five people per household, a minimum of 15,000 people live in these mobile home parks. The parks on the EDA list are mostly without permits and do not comply with local codes.¹² A county official described some of the problems:

The electrical system often does

not have the capacity required for the appliances, the plumbing is corroded, sometimes disconnected. The potable water system and wastewater systems are in some cases intermingled.

This deteriorating situation garnered public attention approximately two years ago, when several individuals were electrocuted in a park by wiring that had not been properly grounded. The county subsequently began to enforce its codes, opting to do plan checks (performed by county inspectors) rather than requiring that parks submit to the full conditional use permit process. The inspections resulted in some individuals being required to leave their trailers, which precipitated a large protest. California Rural Legal Assistance subsequently sued the county, and the Archdiocese of San Bernardino formed a task force to investigate the process. A local county supervisor was appointed as chairman of the investigating group. As a result of these efforts, the county put into practice a loan program to gradually ameliorate the housing situation in a way that would not provoke widespread homelessness among the Triangle's permanently settled farmworker population. The program, discussed in detail in the next section, was created in 1999 and went into effect in 2000.

County Loan Program

Riverside County offers sizable loans to mobile home park owners who wish to improve their sites and bring them into compliance with the building code. There are loans for small and large owners and loans to pay for the permitting process. In addition, there are loans for the tenants to buy new or improved mobile homes or stick-built homes. Loans to owners are

about \$6,000 per site for improvements, and tenants may receive \$30,000 to buy replacement homes. In most cases, the loans become grants if the parties occupy the dwelling for 10 years. This program is widely supported in the community. County officials consider it an innovative answer to unhealthy housing conditions, and tenants that have benefited appreciate the low payments. One family interviewed by the AWHS team reported being very pleased with their brand new trailer, which was much improved from their dangerous former home.

To date, 20 trailer parks with 108 families have been upgraded, for a cost of \$12 million (about half of the families are already in their new homes). The initial monies for the project came directly from the county. Much of the program costs may be attributed to start-up. Nevertheless, the cost of a new trailer is \$30,000 per family plus \$6,000 for associated upgrades to the park. The program cost is thus approximately \$36,000 per family. Multiplied by a minimum of 3,000 families (the number living in out-of-compliance dwellings), the total amount for the program can reasonably be expected to reach approximately \$108 million, excluding administrative overhead.

The county program has also been designed to circumvent potential abuses and obvious pitfalls. It deals with private contractors directly to avoid clients being cheated by unscrupulous individuals. The money also does not pass through the hands of the mobile park owners. A county ombudsman has also been appointed to serve as an intermediary between the county and the community (primarily park owners). The ombudsman has indicated that the loan program has been slowed by

the need for tenants to prove trailer ownership and by the community's fear and reluctance to participate in the program. Indeed, the community's lack of trust in the government was mentioned by several informants as a crucial barrier. To help facilitate the process, the Desert Area Communities for Empowerment (DACE)—which manages the local empowerment zone—recently hired a community spokesman to serve as liaison between the community and park owners. Calling the initiative “The Compadre Program,” the spokesperson, a park owner himself, is actively engaged in trying to get the county and the owners to come to terms on upgrading the parks while minimizing evictions.

The county's loan program is helping significant numbers of individuals escape dangerous and unhealthy conditions. However, it has been somewhat hamstrung by the scarcity of private engineers to approve park renovation projects—as well as a lack of qualified contractors and a dearth of funds sufficient to solve the problems of all who are in need. Unfortunately, given the meager incomes of the tenants and lack of resources among park owners, the program, while laudable, is insufficient to bring relief to most tenants in the medium term.

Trailers on Tribal Lands

Along with mobile home trailers on unincorporated county land, some farmworkers are finding housing in trailers on tribal lands. The two most important areas are Los Duros and La Chicanita, which are both on the land of the Torres Martinez tribe. Living conditions in these areas are unhealthy, with reports of water supplies being contaminated by raw sewage and open burning of plastic and other trash.¹³

The latter is suspected of exposing children who play in the vicinity of the fires to carcinogens (specifically, deadly dioxin compounds from incinerated plastic). Providers reported cancer clusters in certain areas—such as a leukemia cluster at the Oasis school—that may be linked to farmworker living conditions. The Torres Martinez Tribal Council is interested in developing ordinances to control burning and manage water quality and sewage. However, they are in need of resources to ensure that these ordinances, once adopted, can be enforced. Those living on tribal lands are not considered residents of the county and are thus not able to receive

“I’ve had nosebleeds and my sister has blotches on her skin from being in the field with all of the chemicals. My employers refuse to pay so I can get these checked out by a doctor.”

–ECV Farmworker

funds under the county loan program, leaving them few options to improve their situation.

One positive development in this otherwise bleak situation is the construction of a 300-unit mobile home park on Torres Martinez land, funded by HUD and county monies. The county is providing \$750,000 for infrastructure improvements necessary to prepare the parks for occupancy. The development is scheduled to be completed in April 2003. The current residents of trailer parks on the reservation would have the opportunity, at their own expense, to move into that park.

Working Conditions

Many injuries and chronic conditions suffered by farmworkers are a result of substandard labor law enforcement, such as a lack of accessible toilets; inadequate provision of protective gloves, boots, or eyewear; and a lack of potable drinking water. One ECV farmworker explained how she experienced chronic pain due to working conditions in the fields:

When you work in the fields, you get it for life. Your feet hurt later, you break out. They didn’t let you drink water, so your kidneys... it is like a long-term thing, your bladder hurts.

Worse yet, farmworkers are exposed to numerous toxic chemicals while in the fields. Many of these chemicals have been linked explicitly to particular illnesses such as cancer. One farmworker believed her cancer was caused from inhaling the dust and chemicals used in the fields.

Another worker suffering from chronic blistering rashes blamed the pesticides:

I think that all these blisters that are all over my arms and shoulders are because of the chemicals that they use on the grapes. I don’t know what they call the chemical. When they spray in the fields, we have to work in them 2 or 3 days afterwards. The blisters and rash that I have on my arms, chest, and legs began last year and I always have it.

One concerned worker noted some of the many symptoms caused by working in chemical-laden fields:

It's not healthy being in the fields with all of the chemicals. In the grapes, especially. There's a lot of sulfur and there are a lot of people who vomit in the fields. Many have weepy eyes and suffer severe headaches. I've had nosebleeds and my sister has blotches on her skin from being in the field with all of the chemicals. My employers refuse to pay so I can get these checked out by a doctor.

Increased health risks due to field work, chemical contamination, and inability among farmworkers to advocate for themselves have led to a vacuum of needed services in the area. One provider was asked what medical services and treatments were lacking in the area, and he responded: "More emphasis should be given to occupational hazards such as pesticides, dust, and work conditions."

PART II: HEALTH CARE DELIVERY SYSTEM

This section examines health care service delivery in the ECV in three parts. First, we provide an inventory of the various service providers and other health organizations in the ECV, including a brief overview of new one-stop facilities currently in the planning process. Next, we examine how ECV farmworkers are being treated for certain illnesses from which they suffer. We then analyze the multiple channels and barriers that facilitate and interfere with farmworkers' access to health care.

Service Provider Inventory

The majority of the population of current and ex-farmworkers living in the Triangle (especially the uninsured) use a handful of frontline providers in the immediate area, including those available in the town of Coachella. These include the Santa Rosa

del Valle (SRV) clinic in Coachella (which has a mobile unit), the Clínica California in Coachella, the Juan Manuel Acosta Clinic in Coachella, and the Clínica de Salud del Pueblo in Mecca. The largest clinic is the SRV. It is run by a nonprofit group, the Santa Rosa Group, situated in the DACE empowerment zone. The Riverside County Health Clinic on Oasis Street in Indio also serves as a frontline clinic for farmworkers in the ECV, though it is located just beyond the borders of the region.

Beyond the frontline clinics there are other facilities important to the community, although they generally can only be used by those who have insurance. The Novack Urgent Care unit in Indio receives some patients from ECV, as does the Clínica Medica Latina in Cathedral City and the Consultorio Medico of Indio.

There are no hospitals in the ECV. The emergency room at JFK Hospital in Indio receives workers and their families from the ECV. The hospital also runs the Healthy Beginnings perinatal program in Coachella. Patients who are medically indigent go to Moreno Valley Community Hospital to get urgent care without payment—a 90-minute drive for those with transportation. Some medically indigent patients also are referred to Loma Linda University Medical Center in Loma Linda for certain cancer treatments.

Mental Health Facilities

There are very limited mental health facilities for farmworkers in the ECV. The Riverside County Mental Health Department operates a clinic in Indio and receives payment from Medi-Cal for qualified clients. The Indio clinic is comprised of a 23-hour facility, a day treatment program, and a program for the elderly. The facility

REGIONAL ACCESS PROJECT

The Regional Access Project is a health care foundation funded by Riverside County, which focuses on improving health care in the ECV. Its \$1 million annual budget is dedicated to solving access to care issues, and the director is committed to the ECV's development. The organization has directly supported the activities of Lidres Campesinas, Catholic Charities, the Catholic Church's Call to Care, and many others.

is staffed by one psychiatrist and one or two counselors. It can refer out clients when county staff are not available.

The Family Services Center of the Desert in Indio and Village Counseling of Coachella are the other main mental health service providers. In addition, the local Catholic Church has a program supported by the county called Call to Care, which trains mental health paraprofessionals. The idea is to train community people to help each other.

Dental Facilities

There is a distinct lack of dental care in the area. There are a few dentists in Coachella and there is a dental clinic in the Healthy Start Center in the Saul Martinez Elementary School in Mecca, which uses volunteer dentists from Loma Linda. Only documented children qualifying for Medi-Cal can use the clinic. Patients who do not possess insurance either ignore care or

obtain treatments in Mexicali.

Planned One-stop Facilities

The DACE empowerment zone and Riverside County are actively sponsoring the construction of a one-stop health service center near Mecca. DACE is also supporting the creation of another smaller one-stop clinic in Oasis. These centers are being designed to offer farmworkers a wide variety of services, including primary, urgent, and preventive care, as well as mental health. They will also offer health education and child care, all under one roof.

The concept aims to more closely parallel the Mexican model of health care, where different services are available in one location or in close proximity to one another. One community leader explained it thus: "We need one-stop centers that can compete with Mexicali," she said, "and to serve those without papers or transportation." The objective is to reduce time, distance, and other bureaucratic obstacles that currently impede farmworker access to needed treatments and thereby increase the population's participation in comprehensive quality care. (Competition with Mexicali is further discussed below.)

Treatment of Health Conditions

In this section, we discuss both the relative prevalence and treatment of three principal types of medical conditions affecting ECV farmworkers: mental health, chronic disease, and injuries.

Mental Health

Among both worker and provider informants in the ECV, there was near complete agreement that farmworkers suffer from severe and widespread mental health

problems. Only one provider disagreed, though he did admit that domestic violence is an important issue. He stated that “the Hispanic population does not suffer from anxiety or depression, that’s found more in the rich populations.”

But all other respondents reported serious mental health problems. A U.S. doctor who works exclusively with ECV clients as-

WORKERS CONFRONT ABUSE

Documentation status can dramatically affect farmworker self-esteem, and workers with legal status feel that the economic system cannot abuse them as much. One farmworker said that he stood up to his *mayordomo* (farmworker crew leader), telling him that his threats were hollow since he and his family were documented. The *mayordomo* tried to fire the farmworker for complaining about working conditions in a lemon orchard, but the worker insisted that the *mayordomo* and his supervisor (*ranchero*) sign a paper stating why he was being terminated. The *mayordomo* finally relented and told him to go back to work, but two other undocumented workers that complained were fired.

serted that women are stressed because of financial problems, domestic issues, and separation from family in Mexico. A social work counselor added that the living conditions also depress women. A Mexicali-based doctor who sees many clients from the Coachella Valley said that

his clients are depressed due to their legal status, separation from family, and their inability to adapt to new conditions in the United States. A very committed supervisor of outreach workers in the Triangle was certain that 90 percent of the women in the ECV were depressed.

Depression is also associated with the first years in the United States. One Tarascan woman reported extreme distress experienced in her first years because she was separated temporarily from her children. The workers also admitted to depression as a result of money pressures, the problems of raising children as single mothers, and family problems. One very anxious woman stated, “We didn’t know what we were going to do with all these bills. Sometimes I don’t have enough money to pay for the school uniforms for the children. For the problems with money.”

Women who can’t find work often feel guilty and depressed because they are not contributing to the family. Another woman was depressed by a long struggle to get her daughter to attend school. The child refused to go for two years in a row. Another reason for depression among the women is domestic abuse. Women in the ECV who have recently arrived from Mexico are frequently intimidated and mistreated by their partners. One undocumented woman was given \$100 every two weeks to feed herself and children while her husband kept the balance of his \$700 check. Reports of physical abuse were spoken about by several respondents. Finally, the fear of the INS was also a source of depression. The workers felt as if they have to stay at home to stay out of sight, which made them feel isolated and limited in their movements. This has impacted their mental health. Despite the numerous respondents who

professed that they had problems of depression, sadness, or abuse, none reported going to a counselor. One man said that there was no help on either side of the border for his community. Mental health professionals familiar with the area confirm that there is little counseling carried out among this population. As described earlier, there are considerable services available in Indio for the mentally ill, but they don't appear to be used by the poor of the ECV. A counselor who has worked in several branches of the county's mental health division said that probably 1 in 20 of the patients are native Spanish speakers (despite the fact that more than half of the population of the ECV are native Spanish speakers). And these may come from the Indio area rather than the Triangle area. There are many bilingual staff at the county clinic, but very few who are trained counselors or therapists.

The Catholic Church does train Spanish speaking paraprofessionals to become mentors for depressed first-language Spanish speakers. The program is being funded in part by private philanthropy and by the Riverside County Mental Health Department. In five years, it has trained seven mentors.

The low level of mental health treatment among the farmworkers of the ECV is, in part, a function of resistance by the community. The staff at the county clinic claim that a cultural stigma discourages farmworker families from bringing mentally ill patients into the clinic or from enrolling them in the day treatment center. Others report that the farmworker families try to protect mentally ill members of their family from the system. One woman said she preferred praying to seeking psychological help, even though she had just

“There are a lot of people, if they're under 40 and they feel a lump on their breast, they say that it's nothing and that they are too young for cancer. They're misinformed about the disease.”

—ECV Provider

underwent a breast removal operation. Another man who suffered from severe depression after losing his wife relied entirely on his mother for solace.

The Riverside County Mental Health Department does not perceive itself as playing a greatly expanded role in solving the mental health problems of the ECV. They envision themselves as consultants to the natural support systems and agencies already working in the communities. At one time, the county tried setting up a storefront mental health clinic in Coachella, but it failed for lack of clients. School-based programs like Esperanza and Hermanas Intimas, which deal with teenage mothers (many of whom speak English), have had better luck involving participants from the ECV.

One avenue taken by the community is to obtain treatment without counseling. Many are acquiring various medicines for depression in Mexicali, and others are obtaining anti-depressants and anti-anxiety medicines from U.S. doctors who prescribe them unaccompanied by any counseling services. In defense of these doctors and mid-level practitioners, it must be remembered that few Spanish-speaking counselors are available in the ECV. (In addition, there is little incentive for counselors to travel to the ECV, as it is difficult to see an adequate

number of clients per day—payment for services is also difficult to collect). Professional therapists complain that there must be a way to coordinate with primary health care practitioners. The use of medicines without counseling, according to these professionals, is much less effective at achieving cures for mental illness.

Chronic Disease

There are widespread chronic health problems faced by the Coachella farmworker population, including diabetes, asthma, hypertension, and cancer. Unfortunately, workers' isolation from health care institutions too often results in such chronic conditions leading to crisis interventions. This is due to barriers such as language, cost, fear of the INS, and transportation, but it is also due to a lack of health care education.

One provider with breast cancer patients said, "There are a lot of people, if they're under 40 and they feel a lump on their breast, they say that it's nothing and that they are too young for cancer. They're misinformed about the disease." Another of this provider's patients—a 70-year old woman who had not had a mammogram done in 30 years—told her she did not think she needed mammograms anymore because she was not married. Another provider related an incident with a diabetes patient in which a diabetic woman, who was almost in a coma due to extremely low blood sugar, was given more medicine by her family. This put her in a deeper coma, so the family finally brought her to the clinic, and they gave her glucogen, which pulled her out of the coma.

These anecdotes illustrate the dangers of a lack of patient health education. One

provider noted that with diabetes, basic everyday care is overlooked and people only come into the clinics when there are complications. With no preventive practices, chronic conditions, such as diabetes, cancer, or asthma, worsen and patients eventually show up in emergency rooms.

DIABETES

Quite a few providers were concerned about an increase in diabetes patients. A provider at the SRV clinic noted that it is the number one diagnosis there. Diabetes is now considered an epidemic by many providers in the area, and there is a high percentage of patients who do not keep the disease under control.

One provider said that he often described worst case scenarios just to scare patients into realizing the gravity of the disease and to get them to comply with dietary and/or lifestyle changes. An element of diabetes health care education is needed. One interviewee who was eight months pregnant, for example, denied having diabetes at all, though she took Glipizide and Glucophage twice daily, indicating that she had gestational diabetes. Unfortunately, uncontrolled diabetes is leading to permanently debilitating complications, such as blindness and liver failure.

CANCER

Cancer is increasing in incidence in the Coachella region. In the ECV there are limited resources and facilities for diagnostics, and proper follow-up treatment is often found outside of the area. Another factor is that patients lack education about cancer and its causes.

Regarding breast cancer, the mortality rates for certain types of cancers are higher among this population than for other ethnic

groups, despite the sometimes lower incidences. One provider explained it thus:

A common misunderstanding among the Hispanic/Latino population is that, if a woman has a mammogram performed, and if a lump is found, then if they try to cut it out, it will only grow bigger, like a tree. [They say,] ‘Once you prune a tree, it’s going to grow better and stronger.’

Getting care for breast cancer is often a tricky issue. One provider noted that “there are many women who seek services in Mexicali to treat their breast cancer because it’s cheaper and it’s only a two-hour drive from Indio.”

Injuries

Farmwork is certainly dangerous, and occupational injuries occur frequently in

“There would be people with terrible fractures, some with vascular components, going down to Mexicali. On the way to Mexicali, they would have crippling injuries. People were ignoring general surgery.”

—ECV Provider

the ECV. Chronic back pain and other musculoskeletal pain due to specific injury events or to repetitive motion damage are common. While some farmworkers acknowledged that their employers paid for their medical bills when they were injured on the job, most had trouble getting compensated for time off work and full medical bill coverage. For this reason, many

farmworkers do not report their injuries and instead attempt to treat them on their own, go to Mexicali, or leave injuries untreated. Providers stated that often farmworkers only come to see doctors when their conditions become critical. One provider noted that trips to Mexicali after severe injuries were rather common, and often put patients’ health at risk.

There would be people with terrible fractures, some with vascular components, going down to Mexicali. On the way to Mexicali, they would have crippling injuries. People were ignoring general surgery.

Farmworkers are reluctant to utilize Workers’ Compensation insurance due to fear of the INS and fear of losing their jobs. For example, one provider said: “People in this community don’t abuse Workers’ Comp because they know they need to work, and they’re in really bad shape when you see them.”

Channels and Barriers to Health Care

In this section, we discuss the channels by which farmworkers in the ECV attempt to obtain health care, as well as the barriers they encounter along the way.

Language and Culture

Providers in the ECV who treat the farmworker population must cope with language barriers. Many practitioners do not speak Spanish and often have to rely on translators in dealing with patients.¹⁴ Even in the frontline clinics, only 8 of the 15 physicians and mid-level providers spoke Spanish. The need for translators impacts clinic efficiency. Spanish speaking staff are often taken away from their job tasks, such

as drawing blood, taking biometric measures, etc., to translate, which reduces efficiency and increases wait times and reduces the number of patients that can be seen in one day. Hospitals generally have even fewer Spanish-speaking staff than the clinics, so patients have to bring a bilingual friend or relative to their appointments in order to receive treatment.

The inefficiency of having to pull bilingual staff away from their duties to provide interpretive service raises costs for clinics serving the farmworker population. However, some providers claim there is far more to the problem of treating the farmworker population. One provider described the problem in terms of a cultural divide.

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

Another physician in the area lamented:

There is a clash of cultures which makes the Mexican immigrant expensive to serve and you have an impoverished population that can't pay, so you have a deficit of finances. The result is a complicated conflict without an easy answer.

Other providers criticized farmworkers for failing to abide by certain norms. In this sense, these providers assert that barriers to quality care are inherent in the population itself. One provider indicated that farmworkers hamper clinic operations by not heeding appointment times, bringing

entire families to the clinic, arguing about the coverage for which they are eligible, and getting upset or angry with the treatment they are receiving. This provider's clinic required 30–40 percent more labor in order to fill out paperwork, resulting in a 30–40 percent increase in costs to get farmworkers through the system. Some clinics—though not those in the ECV—have attempted to get around the problems by “choosing” which patients they see on

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

–ECV Physician

the basis of their ability to speak English.

Awareness of Services

Related to language and culture is farmworkers' awareness of available health care service. Many laborers in the ECV are migratory and transient, have a low education level, and do not speak English. Many are recent immigrants from Mexico, and many are undocumented, all of which contribute to isolation from health care institutions. A majority do not know of lower-cost clinics in the Coachella area, nor are they aware of social service programs for which they might be qualified. As will be discussed in a later section, many fear all institutions, including those providing health care, believing that any contact will result in their being reported to the INS. Because of this, many

farmworkers either use home remedies or obtain medications from Mexicali. Undocumented farmworkers, who have trouble crossing the border will often ask documented friends to bring back medicines from Mexico.

Many farmworkers experience isolation and disenfranchisement with respect to health care institutions in Mexico as well as the United States. Overall, they lack basic knowledge of formal health care institutions and the ways they can utilize services. When one interviewee was asked about health care assistance programs in Mexico, she claimed to have heard the name of one, but was unaware of whether she qualified for it or how to utilize the program. Some also seemed confused about the concept of insurance. For example, one farmworker thought “*aseguranza*” (the most common Spanish word used for “insurance” by this community) was a birth certificate. Others believed they had received substandard treatment because the doctors they saw were “Workers’ Comp doctors.”

In cases where farmworkers did become knowledgeable of health services, it usually was a result of word of mouth or some form of direct outreach. For example, the mobile unit from the SRV clinic and other programs that enter isolated farmworker communities have had considerable success in introducing farmworkers to U.S. health care institutions. One farmworker noted that his family was not yet established in the area, and they were thus not yet familiar with available services. However, they did know of the mobile clinic from SRV because they saw it parked at La Chicanita store every Thursday at 10 AM.

Cultural Brokers

Clearly, the population of the ECV needs more intermediaries, or cultural brokers, to help find out about, qualify for, and effectively use health care services. Many foremen at job sites, landlords, and more experienced long-term residents of the area provide advice to those unable to negotiate the system. However, most of the workers still feel extremely uncertain about accessing services in the towns to the west of their residences.

One key set of cultural brokers are *promotoras* (health promoters). Not only do *promotoras* go door-to-door to educate people about services, they also set up appointments, help patients fill out forms, and describe eligibility requirements. Some *promotoras* also give providers and programs feedback from farmworkers regarding types of services they would like to receive and the obstacles to care that they face.¹⁵

An example of a program that utilizes *promotoras* successfully is Planned Parenthood of Coachella. The program focuses on female and reproductive health, and the director monitors the team closely for performance. Outreach workers visit clients in their homes, provide basic health education, and offer translation and interpretation for the Planned Parenthood family nurse practitioner, who travels all over the ECV delivering health service to women. The *promotoras* follow up with the women to make sure they are continuing needed treatments. There is also one male *promotor* who works with the men.

Another outreach program with considerable success in the area is Lideres Campesinas. Outreach workers provide

basic health education and distribute fire extinguishers and smoke alarms to households. When appropriate, they broach topics regarding domestic violence. The director maintains a strong monitoring system. Catholic Charities has also been funded to do similar outreach to the community.

Other outreach resources in the ECV include the Farmworker Family Center in Mecca, which is sponsored by the Riverside County Social Services Department. The facility provides telephones, computers, a meeting room, and several other rooms to visiting service providers. It opened in June 2001 and is a hub of activity. Services include English classes—with day care for 20 people by the Campfire group—classes for custodial services, and immigration counseling twice a week sponsored by DACE. In addition, the Center for Employment Training (CET) conducts an adult training program at the center; county mental health officials offer *Hermanas Intimas*, a program for pregnant teenagers; and Social Services conducts enrollments for Medi-Cal, Food Stamps, CalWORKs, and GAIN (Greater Avenues for Independence Program). An Employment Development Department outreach worker also meets clients there to provide employment-related advice, and the county's mobile home improvement loan program also uses it as a meeting place.

Other important cultural brokering programs in the ECV include the *Esperanza* program, a counseling program for teenage mothers in the schools, and *Shelter from the Storm*, a program for battered women. The Social Justice Committee, a key informal community-based group, does extensive work organizing and providing outreach in the community. They specialize

in improving housing and living conditions.

Cost and Ability to Pay

One major problem in the ECV is the high cost of medical care for farmworkers. Fortunately, some clinics have the knowledge to efficiently bill farmworker health care costs to the correct public program (a key success factor for clinics). However, many farmworkers often prefer to pay for health care in cash. Farmworkers perceive cash services as better than those received through assistance programs. One former farmworker explained: “If you pay for

“If you pay for something, you get good service. When the government program pays, they treat you like animals.”

—ECV Farmworker

something, you get good service. When the government program pays, they treat you like animals.” Other research has shown a similar preference.¹⁶

Yet many farmworkers often do not have the cash needed to pay. Throughout the social networks of farmworkers, there are many cautionary tales circulating about costs, inhibiting health-seeking behaviors.

Low-income and Other Assistance Programs

The main programs available to farmworkers in the ECV are: California Children Services (CCS), Child Health and Disability Prevention (CHDP), Breast Cancer Early Detection Program (BCEDP),

Family Pact, Medically Indigent Services Program (MISP), Healthy Families, and Medi-Cal. In general, there are few programs that serve adults, with the exception of pregnant women and women over 40 for BCEDP. Practitioner knowledge of program eligibility is not always adequate. Although a case-management approach would be ideal, where patients are matched to extant programs, it is currently not practiced on many occasions due to a lack of information and resources at the provider level. Clinic fee schedules are often complicated, requiring health advocates to have deep knowledge of the local clinics in order to provide case-management-like solutions.

Confusion about the various program eligibility rules sometimes existed within the same clinic. For example, a couple of providers thought that MISP patients must be documented, while others knew that patients qualify despite documentation status. Another common misunderstanding was related to the age of children eligible for CHDP.

Eligibility for many programs is limited by documentation status. However, even programs that do not require U.S. residency, such as MISP, have other requirements, such as proof of county residency (for example, in the form of a utility bill).¹⁷ As explained by a local physician, this can be a difficult hurdle for some ECV residents to surmount. “Many people don’t fit in any program because they don’t have county residency. This would include the undocumented from Indian lands, transients, or people who migrate and don’t achieve residency.”

Detailed below is a summary of issues

surrounding various health programs in the ECV for which we have data.

CHILDREN’S HEALTH

There is often confusion on CHDP eligibility. Officially, the program is open to all children until 90 days after entrance into the first grade, Medi-Cal enrolled children, and non-Medi-Cal eligible children whose family income is 200 percent of the federal poverty level. Eligible children in Mecca schools can go to Saul Martinez Elementary School for dental care. Often providers are under the assumption that all children are eligible until age five, which is technically incorrect. In the ECV, CHDP care typically follows the following process described by a clinic administrator.

They have a lot of children that come from Mexico and it is their first time here. In order to qualify for school they have to get more vaccines and a [physical] exam. They put all those children on CHDP. Most qualify for CHDP. For most of the kids [the service provider performs] only physicals and there is only blood work to see if they are anemic. Many are behind in vaccines. [California] requires more than in Mexico.

CERVICAL AND BREAST CANCER

There are no programs for cervical cancer in the ECV, which is a problem due to the fact that farmworker males sometimes engage in risky sexual behaviors and may be carriers of one or multiple strains of proto-cancerous *human papillomavirus* (HPV).¹⁸ Given that the farmworker population is not likely to engage in preventive health-maintenance behaviors like pap smear tests, due to lack of health education or a cultural taboo, the relative incidence and prevalence of cervical cancer in the

area is likely to be high. Moreover, the conventional medical establishment often views cervical cancer as a “woman’s problem,” as it is up to women to seek regular pap smear tests and to insist on use of condoms until marriage. This is built on the assumptions that women are not bound to cultural norms of behavior, that marriage equals fidelity, and that a woman’s partner is not already an HPV carrier.

There are breast cancer detection and treatment programs in the ECV. Under these programs, the Department of Health Services (DHS) provides income-eligible women age 40 and older with free clinical breast examinations, and women 50 and older with free mammograms. Women ages 40–49 with a personal or family history of breast cancer may also receive free mammograms. BCEDP pays for the initial breast cancer screening and initial physician consultation for women over the age of 40. If the doctor finds a problem, then BCEDP will pay for additional diagnostic testing such as ultrasound. It will pay for the first biopsy and the surgeon’s consultation fees. The problem is that there are many women under the age of 40 that still get breast cancer.

MEDI-CAL

Medi-Cal eligibility focuses on income, family size, and age of U.S. resident applicants. Emergency Medi-Cal applies to pregnant women, regardless of immigration status. One *promotora* in the ECV, who mostly helps people with Medi-Cal and Healthy Families applications, noted that most prefer Healthy Families to Medi-Cal.

People always come here because they want Healthy Families, they never come here for Medi-Cal.

This is because Healthy Families covers a wide array of services like dental, medical, pharmacy, optical, etc. Whereas Medi-Cal only covers provider visits. If a family is undocumented, then they’ll file the Medi-Cal form as an emergency, but most kids are citizens. Emergency Medi-Cal does not cover vaccines.

Medi-Cal can be retroactively billed, so practitioners have routines in place to deal with patients who are likely to be covered. “If we think they are going to get on Medi-Cal, we will just put them on sliding fee and then retroactively put them on Medi-Cal,” said one practitioner. Many providers try to deal with the uninsured by using a sliding scale and offering laboratory work at a discount rate. Yet there are still some misconceptions. One provider seemed to have a blanket generalization that was incorrect. “If you have a kid that doesn’t have Medi-Cal and is six or more years old, the family pays for the office visit.”

In the ECV, Riverside County is the HMO for Medi-Cal mental health. County services also have a sliding scale for the uninsured. The payments can be as low as \$5 per session.

MEDICALLY INDIGENT SERVICES PROGRAM

The Medically Indigent Services Program in Riverside County (MISP) offers many ECV residents the opportunity for care, regardless of documentation status. Some providers in the area are under the impression that one needs a Social Security number or a green card.¹⁹

The reality is that it theoretically is not that difficult to obtain MISP care, all that is needed is proof of county residency. But, as indicated in the provider quote below,

obtaining MISP coverage in the ECV is not necessarily fast.

It is pretty easy to get on MISP. You can mail in an application but it takes three to four months for approval. If you go to Moreno Valley, you can get it on the same day.

Health Insurance

Most workers reported having no health insurance. Employers are known for not providing health insurance to their seasonal workers, which comprise the majority. Those employers that do provide insurance tend to utilize policies that favor medicine obtained in Mexico. Other non-farm workers in the ECV have insurance but tend to pay high premiums.

There are various elements of the insurance system that professionals pointed out that affect the quality of care. One doctor noted that each insurance company has its own “formulary” for medicines that it approves for given ailments. He said that he finds himself giving patients not what they need, but what he is allowed to give. Others are often placed in the difficult position of coaching farmworkers to “frame” their medical condition or situation in a certain way in order to receive specialist care.

One question that arises is whether or not split insurance coverage in families (some are covered and other are not) is a problem. Reflecting a common sentiment, this provider felt that it is not a big problem for clinics.

The parents pay cash and the children are insured. They have a lot of seasonally insured. Every time they come in we ask them. If

they lose their insurance, [we] just put them under sliding fee. They bring in pay stubs for sliding-scale assessment. They are charged according to their income. Most of the changes can be done in the computer. It is not hard to switch it.

A problem occurs when a seasonally insured patient has a complication or referral during a period without coverage. Unless they are able to pay the high cost of specialty care—and very few can—farmworkers forego additional care. If they have a binational health plan, they will go to Mexico because that is the only place they are fully covered.

Immigration Control

The ECV is a “landing area” for many recent immigrants. The INS, known colloquially as *la migra*, has a strong presence in the area. The mobility of the population is often restricted by INS checkpoints. An outreach worker in the area described the impact these checkpoints have had. “People from Coachella prefer not to even go grocery shopping in Oasis because they fear immigration. This fear is exasperated during the months of December to July when immigration presence is strong.”

This limitation on mobility inhibits farmworkers from seeking health care. INS roadblocks curtail farmworker movements between the ECV and Brawley in Imperial County. Farmworkers also fear being interdicted by the INS between the ECV and Moreno Valley Community Hospital.

One doctor noted that checkpoints on Highway 86 within the ECV dramatically affected patient flows: “Highway 86 lies between the clinic and Desert Shores. At times the INS sets up a roadblock which

empties the clinic of Hispanics on that day. INS sets a mobile roadblock frequently.” The roadblocks affect referrals and exacerbate the problems associated with a lack of access to specialist care. A nurse in the ECV mentioned that “many times we have made the appointments and they haven’t shown up because they can’t get there or they’re afraid to go there.”

The INS has created an atmosphere of fear in the region, and any institution that has the appearance of being the INS is avoided. In fact, outreach organizations and clinics have to be careful about even having

“The main problem is not a lack of desire or funding, but transportation. We haven’t got a practical solution to the transportation issue.”

—ECV Provider

procedures that resemble those of the INS—for example, paperwork or the use of Social Security numbers. The workers are afraid that if they give out personal information they will be reported to the INS. One outreach worker stated: “Oftentimes patients will give false addresses, phone numbers, etc. They’re also afraid of being sent to the INS.”

As mentioned earlier, the fear of *la migra* affects farmworkers’ mental health, causing workers to often feel trapped in their homes. The INS presence also causes a lot of stress, since farmworkers feel that when they leave home, they don’t know if they are going to come back or not.

This fear of institutions also affects many

facets of care, including health education and continuity of care. *Promotoras* entering into communities have to clearly mark their vehicles to distinguish them from the INS. This anti-institutional attitude also drives patients to seek care across the border in Mexicali, as medical providers there do not ask for detailed information about the home. One practitioner in the ECV said of farmworkers: “They have a fear of government. They are afraid of asking for information and of government knowing what is going on in their home. That’s why people go to Mexicali.”

Transportation

Traveling to Mexico to obtain health care is indeed a significant undertaking for farmworkers in the ECV. But even traveling to local clinics is not without serious challenges. One local physician noted that transportation was strongly linked to ECV health problems, “The main problem is not a lack of desire or funding, but transportation. We haven’t got a practical solution to the transportation issue.”

Four primary issues exacerbate health-related transportation problems in the ECV: (1) workers often cannot afford a car, and if they can, the male head of household uses it to get to work; (2) the community is dispersed throughout remote, isolated pockets (including tribal lands), (3) access to specialist care is invariably outside the area, and (4) to obtain service as an MISP enrollee requires travel outside of the ECV.

Practitioners in the area emphasize that transportation is of vital importance. One indicated that many times farmworkers don’t show up for the appointments because they simply can’t get to the clinic. The problem impacts the ability of farmworkers to obtain specialist referrals,

which often requires travel outside the area.

The elderly are even more limited than the general population. One respondent stated that the elderly have an even harder time getting access to health care because they have absolutely no means of transportation. “At least, [we] young folks have the option to walk if we [have] to,” she said.

Timeliness of Service

Related to transportation is the problem of the timeliness of service. Clearly, delivery of health care service must occur in a reasonably timely manner to be effective. For those ECV farmworkers ineligible for low-income assistance programs and those unable to pay cash for services, care is obtained outside of the region. This frequently imposes a time and distance delay that hampers the delivery of quality services. Some who do not have the cash to pay receive indigent services at Loma Linda University Medical Center or Moreno Valley Community Hospital, which are both at least an hour and a half away.

Another problem is that the local ECV clinics are overcrowded and have long wait times. Their hours of operation are also out of synch with the hours that farmworkers are off work. Some farmworkers have found a solution in Mexico. A county outreach worker indicated that though service can sometimes be faster in Mexico, getting there is time consuming.

Private pays in Mexicali do not have to wait. It is those covered under an insurance plan that are forced to wait. [One farmworker] sees [a doctor] in Mexicali, [she] works at the packinghouse and has

Transwestern. People don’t like to go there because it is time consuming. [Her daughter] would take her at 6AM and leave at 3 PM. People don’t have other options. Most people go to the doctor at the end of the week.

Also, depending on the circumstances, service speed in the Mexican public health system can be extremely slow. For example, one Mexican doctor explained that if someone wanted to get an operation at the Seguro Social (a Mexican government health institution for public employees and those employed in formal sector), the wait period is tremendous. He said that if a person needed a surgery done in March, they wouldn’t get an appointment until July. But if he went to a private surgeon, the patient could get the surgery done the next day.

Service Refusal

In addition to traveling long distances and enduring long waits for service, farmworkers are sometimes flat out refused care. A health program coordinator explained that paperwork mistakes and other bureaucratic glitches can result in denied coverage.

The forms can be rejected because they weren’t filled out completely or because of income qualifications. The challenge with this type of coverage is that people have to reapply every year and to make payments once a month. If they don’t pay a month, then they’ll get a notice in the mail. WIC [Women, Infants, and Children] is thought to be a more successful program than Medi-Cal because it’s more accessible and because there’s less paperwork. WIC also provides great nutritional education, has less

requirements, and it's also more personable.

However, some clinics can appear to consciously ignore rules for various programs, creating ethical dilemmas. One practitioner noted the reality of being seen by a doctor and the common practice of “patient dumping” in the ECV.

People have to wait long hours for stomach pain in an emergency. But if you are smart, you'll complain of intense chest pain to get in to see the doctor. The doctors fear a lawsuit so they will take you. Many doctors practice defensive medicine and protect themselves legally by referring people to specialists.

There are indeed fewer problems with urgent care. One physician explained why this is so: “If there is an emergency then they will be taken care of, otherwise there won't be treatment... There is a federal law—COBRA or emergency medical transport law—which prohibits a hospital to discharge a patient in need of urgent care.”

Patients' ability to pay for services also comes into play. Fortunately, there are doctors in the ECV who try to see patients regardless of their ability to fully pay. One source described a screening process that tried to accommodate the uninsured.

The ones who are IEHP [Inland Empire Health Plan] or Molinas we never refuse. But we triage them to see if they can come in the next morning at 7:30. During the day all are seen but at the end of the day the insured ones can get seen more easily. There is no cutoff as to walk-ins. If they don't have the \$30, we ask for \$5 or \$10 and

collect it later. We turn away no one.

But for those physicians trying to do the right thing, resistance may come from the larger institution. If a doctor agrees to accept a patient, the hospital may object so that the treatment is not performed.

The Referral System

Contemporary medicine in the United States is highly dependent on specialists. It is precisely the step of referring patients to specialists that presents the greatest problem for primary care providers serving farmworkers in the ECV. This is particu-

“People have to wait long hours for stomach pain in an emergency. But if you are smart, you'll complain of intense chest pain to get in to see the doctor.”

—ECV Provider

larly true for uninsured clients. As one nurse practitioner who serves in an ECV clinic put it, “The biggest barrier is the lack of ability to pay for many of the clients. When we have to send patients to referrals that leads to difficulties.” Similarly, a leading physician reported that due to farmworkers' inability to pay, “If they have a problem, they probably won't be seen by a specialist in this valley.”

Nevertheless, there are some positive signs regarding ECV specialist care. Treatment received by pregnant women is particularly noteworthy and serves as the best model of quality specialist care for the

area's low-income individuals. The reason is that the clinics and specialists understand that Medi-Cal will cover payments. The process works as follows: First, women are put on Presumptive Medi-Cal. If the patient's laboratory test indicates a problem, then the frontline clinics can transfer the case relatively easily to an OB/GYN in reasonably close proximity. The women, in general, are motivated to go to the appointments, although transportation was reported as a problem by some.

Other cases that have worked well have involved referrals to a cancer surgeon in Indio, who has a good reputation with the Hispanic community and can charge BCEDP for her work. A third example is for children less than six. The CHDP program will pay for most referrals to specialists resulting from the CHDP sponsored examination. However, for other medical issues the referral system often does not work well.

If patients can qualify for MISP by demonstrating that they are residents and are impoverished, then they can be referred to Moreno Valley Community Hospital or Loma Linda University Medical Center. For those that cannot demonstrate that they are residents of the county because they live on tribal land or because they don't have a rent receipt, there is no assistance program available. As one provider said:

When they (the uninsured) show up with a significant medical problem that needs a specialist, basically we tell them they have to go back where they came from because there is nowhere in the U.S. where we can get a specialist to work without payment. If there is an emergency, then they will be taken

care of, otherwise there won't be treatment.

Nevertheless, there are some specialists willing to do pro bono work. Also, at least two dentists in the Indio area indicated a willingness to provide service without charge when patients were referred from the schools. But as single-physician practices diminish, so has the frequency of pro bono work.

One social work counselor said that many people fall through the cracks because they don't speak the language and have no one to go with them. They just decide not to go to a specialist. The workers in the Lideres Campesinas outreach program said that at times they accompany referred patients to a specialist's office. And even though they don't speak English, the individuals from Lideres Campesinas provide a useful support service for farmworkers.

Another problem is that certain specialties in the area are entirely unavailable. For example, there are no neurologists for those who experience seizures, a frequent problem in the ECV population.

The clinics have very mixed methods of tracking whether their referred patients actually get served by specialists. The frontline clinics have people in charge of doing this task, but it is difficult to accomplish. One provider said that he often refers clients for emergency services without a referral slip when he thinks they need to see a specialist. If he sends them with a slip, his experience is that they are sent back without treatment. He keeps no track of these referrals and thinks many go straight to Mexicali. Another small clinic located at a school indicated that no follow-up is done on referrals due to lack of

time.

One major occurrence is that referred patients who actually make it to the appointment don't understand the treatment they are supposed to receive. Several doctors said that the majority of their patients who make it to the referral come back and ask what to do with the information they have received. According to one FNP in the ECV, only 20 percent of the referred patients get what they need as a result of the referral.

One doctor said that he does much of the work that specialists do. He says since the work is probably going to come back to him anyway, he may as well take care of it before it gets more serious. "Out in the farmworker neighborhoods one has to be more aggressive than in other places because one is far from the specialists and it is difficult to involve them," he said. Because of the waits and the inability of the farmworkers to get adequate care from specialists, this doctor just tries to solve as many problems as best he can himself.

Some providers actually refer patients to Mexicali. One doctor and one nurse practitioner indicated that it is sometimes necessary to do so to avoid injury to the patient. One Mexicali-based doctor said there are many competent specialists in town. He added that laboratory work is usually as good as that done in the United States. Considering the wait times and the far greater costs on the U.S. side, some providers simply use their contacts south of the border and make referrals.

One universal theme that emerged from interviews with providers and workers is that the specialists need to come to the farmworkers, not vice versa, if they are to

deliver effective service. One doctor said that specialists need to come once or twice a week to the farmworkers' neighborhood in order to serve the patients properly. Another said it would be easier for specialists to come to the patients in this region rather than workers going to the specialist.

Provider Collaboration and Conflict

In the ECV, health care staff collaborate on an individual level. Yet some expressed feelings of being isolated and would like a more robust professional network. Clearly, there is a problem with keeping talented people in the ECV, as one interviewee said,

One universal theme that emerged from interviews with providers and workers is that the specialists need to come to the farmworkers, not vice versa, if they are to deliver effective service.

"Most people that have the qualification of [being] highly trained and speaking Spanish don't stay in Coachella because of the chaos."

Institutionalized collaboration between organizations is limited. Some clinics collaborate well with each other, but there are strained relationships and competition. "There [are] enough patients for everybody. I don't know why we have to compete," said one clinic administrator. A doctor added that it's difficult for providers to collaborate because of money, politics, and power hungry people.

Such clinic rivalries and competition often limit services to farmworkers or create difficult obstacles. The atmosphere among providers can even be hostile. They some-

times accuse each other of overcharging patients, of setting policies that limit care (for example, charging high fees for transferring patient records), and not delivering consistent service.

However, there are instances in which community agencies get together to discuss ways of improving services. For example, DACE is fostering collaboration between a local clinic, California Rural Legal Assistance (CRLA), and the Rural Community Assistance Corporation on a training program to improve the housing condition in mobile home parks.

On the binational level, collaboration among providers is quite limited. For the most part, medical records are not shared across the border. One Mexicali doctor expressed frustration with his counterparts to the north:

The American way is very confined. They do not allow the Mexican *medico* to interfere with their patients. Not all of them, because there are doctors that if I send the diagnostics they will accept them. But I send them out with their X-rays, lab tests, and diagnosis, and my opinion as a *medico* and what I would do as a *medico*.

Another Mexicali doctor has not been as fortunate. He had a patient with a gastrointestinal hematoma and the patient told him that he had insurance in the United States. The patient wanted to get the surgery done in the U.S. system. The doctor then wrote the surgeon a letter and included the video he took of his patients' gastrointestinal tract and medical history. The U.S. provider never responded back. Another Mexicali doctor said that such response failures are very common.

In addition, Mexican providers see a large portion of the American patient population, which some believe has inspired resentment on the part of American physicians. One Mexicali doctor indicated: "I think I see 60–70 percent of the Calexico [a border town] population and they [U.S. providers] don't like that. It does not sit well with them to say that [a Mexican] doctor is good."

Low Service Demand and High Turnover

The health care habits of the population and the lack of paying customers makes it difficult for a physician to make as good a living in the ECV compared to the affluent West Valley. There are not enough insured patients to keep a doctor busy with billable patients through the day. As a result, it is hard to attract and keep a physician in the region because of the lower income it implies.

In addition, physicians, mid-level practitioners, and support staff also experience high turnover due to the difficult challenges in the ECV. Managers indicate that providers get tired of the chaos, the misunderstandings, and the barriers to care. The quality of care is greatly affected by the turnover.²⁰ As one physician put it: "What is needed is high quality providers that feel comfortable giving care to the population. If you can get this kind of people to Coachella and keep them there, you can solve 90 percent of your health problem."

Preference for Mexicali Treatment

Some providers claim that the health care system in the ECV is in direct competition, at least for the legal resident farmworkers, with the health care system in Mexicali.

One Mexicali doctor reported that American medicine is too specialized. He said that at the bottom of the health care pyramid you need a family doctor who can communicate with patients, take time with patients, not just refer them to a specialist.

Many farmworkers also reported that in the United States they received rude or poor treatment, experienced high costs, and encountered language barriers. Several workers blamed the poor service they received on racism toward Hispanics. One man said, “They don’t have eyes that see the Hispanos. In the emergency room they don’t give you any service but still send you a bill. We are invisible and there are no services provided for us.” When asked why he preferred Mexicali doctors, another farmworker indicated:

Because I don’t like the services here. Here they take blood, you have to return another time for the results, and they give you a Tylenol. In Mexicali, everything is taken care of in an hour.

These accusations, deserved or not, lead to a reputation problem among providers. In turn, this leads workers and their families to avoid health care locations in the United States, while increasing the pressure to go to Mexicali as a first recourse.²¹

Another element that attracts farmworkers to Mexicali is that services are relatively concentrated in one area. One social worker explained that “Most of the workers go to Mexicali where there is a one-stop service with X-rays and a dispensary in the same building. It is also cheaper and there is less of a wait there.” She claimed that the waits at some U.S. clinics take longer than driving to Mexicali.

In general, workers expressed a rather nuanced awareness of differences in services, methods of treatment, and the culture of health care in Mexicali versus the United States. Many told stories of trying out several providers often on both sides of the border with a certain ailment or problem. One man had an allergic reaction to shrimp in Mexicali. His family took him to one doctor who treated him with medicines. When these didn’t work they went to another Mexicali doctor who finally was able to get the problem under control. Another man told us that he goes to six different doctors in Mexicali. He drives around looking for the one who is available to treat his illness. He said that “sometimes you get good treatment and sometimes you don’t.” This same individual is a severe diabetic. During February 2002, he went to an ECV clinic where his glucose level was measured at over 600. Since he had no Medi-Cal, he took a dangerous trip to Mexicali, where he received dialysis.

One woman—who said she combined using doctors and medicines in Mexicali and visits to U.S. clinics—went to an ECV clinic for treatment of a bad rash. They gave her a cream but it didn’t help her. They referred her to a specialist, but since she had no Medi-Cal she decided to do nothing more about it. She had no money for consultations or treatment. Another man, who had Medi-Cal for himself, his wife, and five children, indicated that he uses Medi-Cal for simple problems, but if something serious were to occur, he would head straight for Mexicali.

Many times the same people have good and bad experiences in the same places. One man had a successful hip operation in Mexicali (at a cost of \$5,000), which he

was very satisfied with. However, the same man had a cataract operation in Mexicali (at a cost of \$1,000) that failed. He blamed the outcome on the doctor.²² One woman recounted the story of how the *sobadores* in Mexicali vary in quality. Her brother had to go to a few before he was able to get relief for his pain symptoms.

One woman clearly and emphatically stated her preference for Mexican medicine. She said that she loves the services in Mexicali. The physicians not only speak Spanish as their first language, are familiar with “our diseases” (culture-bound diseases), but they are quick and have less paperwork.

“Here [in the U.S.] they take blood, you have to return another time for the results, and they give you a Tylenol. In Mexicali, everything is taken care of in an hour.”

–ECV Farmworker

But this same woman tells of incidents which contradict the credibility of her own statements. First, she said that her mother had been greatly harmed by Mexicali doctors overprescribing medicines. Despite their protestations to the contrary, Mexican farmworkers are clearly somewhat equivocal about which medical system is better.

ECV providers tended to question the quality of care in Mexicali, particularly with regard to preventive care. A consciousness about preventive care seemed to be less prevalent south of the border. Indeed, doctors in Mexicali said that they

served their patients when they were sick. Another medical assistant in a cancer ward pointed out that sometimes women would get misdiagnosed in Mexicali. The doctors would identify a cyst with a mammogram when an ultrasound is really needed to confirm a problem. Another *promotora*, who is a Mexican herself and goes to Mexicali, complained that the quality of service is highly variable in Mexico. “If you’re lucky go to the right person,” she says, “but you don’t know and go to the first doctor you find.”

MENU OF COMMUNITY-BASED INTERVENTION OPTIONS

1. SUPPORT FOR ONE-STOP HEALTH SERVICE CENTERS

The centerpiece intervention in this menu of options is to further catalyze the development of one-stop health service centers in the ECV. This is an intervention favored among service and health professionals in the region and among the farmworker community.

The first such centers are already actively being pursued. The DACE empowerment zone and Riverside County are sponsoring the construction of a health service center near Mecca and supporting the creation of another smaller one in Oasis. (In addition, the Coachella Valley School District is planning to build a large K-12 school complex between two areas on 66th and Tyler Streets, which may be able to serve as another one-stop center for many of the services.) These centers are being designed to offer farmworkers a wide range of services, including primary, urgent, preven-

tive, and mental health care. They will also offer health education and child care. The one-stop concept aims to reduce time, distance, and other bureaucratic obstacles that currently interfere with farmworkers' access to needed treatments and thereby increase the population's participation in comprehensive quality care.

Clearly there is momentum for constructing the needed roads, sewage, potable water, and other brick-and-mortar elements to make the one-stop facilities a reality, all of which will be largely financed with public funds. However, this represents only part of the solution in bringing adequate health care services to the farmworker community. In addition to these physical assets, there is the need to ensure that health care offered at these centers will meet the needs of the population and that the associated support services are available. Below are specific areas in need of support that would help ensure the one-stop centers' success.

Transportation. This is a first priority. The surrounding areas have trailer parks, apartments, homes, and populations of the homeless. Many of these people are isolated during the day, and the public transportation system is totally inadequate to the task. A van service that circulates among the communities can deliver people to the one-stop centers.

Culturally Sensitive Specialist Care. Providing specialist care is second in the list of priorities. Cardiologists, ophthalmologists, rheumatologists, podiatrists, endocrinologists, and others would be routinely needed at the centers, with scheduled visits occurring on a weekly or bi-weekly basis. This would allow primary

care providers to be on hand to consult with specialists (who rarely speak Spanish) and to interpret treatment options to the patient. Medical assistants and others could also be enlisted to provide translation, interpretation, and moral support to follow recommended treatments.

Child Care. The one-stop centers need to provide child care so that parents can attend to the sick relative or receive treatment themselves.

Other Services. The centers would offer a range of other services needed and underutilized by the community. As with specialist visits described above, routine planned visits are needed by service providers in mental health, alcohol and drug abuse, enrollment in services, and others.

Expanded Use of Promotoras. The centers would need to be supported by an expanded *promotora* or intermediary staff to complement the already existing ones described above. *Promotoras* who visit the homes are crucial for getting people into the centers for care, for making sure they keep their appointments, and for assuring they comply with treatment. The provider staffs need intermediaries (i.e., patient navigators) to be successful with this population.

Urgent Care Center. The inclusion of a 23-hour urgent care center at the Mecca clinic would expedite care and relieve the overburdened centers at the JFK Hospital in Indio and at the Moreno Valley Community Hospital.

Health Education. The one-stop centers should also provide effective health education and parenting classes. This could include support groups organized by town

of origin, by health condition, or by other factors. These could be led by providers or by health educators.

ESL Training. The one-stop centers could provide training in ESL coupled with education in the health care field. The County Economic Development Agency already has a start-up program in this area. The high turnover and low wages of the medical and nurse assistant staffs require a constant influx of new bilingual staff.

2. UPGRADING FARMWORKER HOUSING AND LIVING CONDITIONS

Expand County Loan Program Intermediaries. The county loan program is difficult for many farmworkers to understand, and more individuals are needed to help explain and enroll individuals in the program. These intermediaries should be based in the community and could work for a nonprofit organization in the area. One idea is to expand the *compadre* program currently being run by DACE, in which successful applicants are hired to train new applicants to the program.

Extend County Loan Program. The county loan program should be extended to Torres Martinez tribal land (or alternatively, a parallel non-county program should be created to include Torres Martinez). At present, those farmworkers living in trailers on tribal land are excluded. Since some of the worst conditions are found there, expanding the program to include some of these individuals would be useful in improving farmworker health.

Develop Ordinances. The Torres Martinez Tribe should be provided with resources to design housing, sewage, water, and other ordinances that bring them into line with

similar county ordinances. They also need resources to hire enforcement staff to ensure compliance with the new tribal ordinances.

Broker Engineering Services. Resources should be directed towards obtaining needed engineering services to obtain approval of plans for rehabilitating trailer parks. The lack of such services is currently causing a bottleneck in construction loan approval.

Offer Dental Services. The housing units being put in Mecca by the Coachella Valley Housing Coalition should be complemented with small dental and service clinics.

3. SUPPLEMENTARY INTERVENTIONS

Expand Mobile Unit Services. Mobile units should include a mental health component, and they should be backed up by *promotora* staff who can follow up with clients.

Increase Culturally Competent Staff. The ability to attract more culturally competent physician's assistants and nurse practitioners to the area must be enhanced.

Extend Binational Health Education. The possibility of extending the health education component to the Jiquilpan and Ocumicho areas of Michoacán as well as the San Luis Coyotlan area of Jalisco should be investigated. These three areas are the points of origin of many of the farmworkers found in the Triangle area. Since women are generally the ones responsible for health care in the family, and since many do not accompany their spouses north, a health educational program would gain in effectiveness by

bringing its message to these areas.

Facilitate Binational Cooperation. Collaboration among U.S. practitioners and practitioners in Mexicali and Coachella should be further investigated. This would help increase understanding among those on the front lines regarding how farmworkers seek out services. At a minimum, provider training about health care in a binational context should be offered in Mexicali and Coachella.

NOTES

¹ TCE has defined 10 subregions for use in the AWHS baseline case-study series. These comprise relatively cohesive units, exhibiting unique health care and institutional problems. Each subregion roughly encompasses a commuting area in which farmworkers travel to and from their residences, work, and medical service-delivery areas. The subregions were chosen to ensure representation of all the types of farmworkers, the breadth of health issues affecting them, and the varied geography of agricultural California. By using these subregions, TCE and the AWHS team are able to accurately analyze *community-specific* health care issues affecting farmworkers, while effectively tailoring and implementing workable solutions.

² The ECV currently has an overall population of approximately 100,000.

³ In contrast, the per capita incomes on the central and west side of the valley, in towns such as Palm Springs, Palm Desert, and Indian Wells, are typically above the \$40,000 level.

⁴ See Gabbard, S., Kissam, E., and Martin, P., “The Farmworker Undercount,” U.S. Census Bureau Conference, 1996.

⁵ Eastern Riverside County Health Assessment, 2000.

⁶ Solo males are defined as farmworkers who are unaccompanied at their current residence by a spouse, child, or parent. About half of all farmworkers fit this description.

⁷ Most of the adults are first-generation Mexican immigrants, with the majority having come from Michoacán, Jalisco, or Mexicali (County of Riverside Economic Development Administration, U.S. Census Data, 1990.)

⁸ Many of these added workers double up in the

available living space, further crowding the residents, or live under trees or in their cars.

⁹ It is difficult to obtain employment statistics for the Coachella Valley only. Many of the workers leave the area in the hot summer months, but the majority stay. Statewide, only about 15 percent of farmworkers work in one crop area and then follow the crops to other areas. However, among the labor force there are many newcomers or first-time arrivals to California agriculture, and workers who travel to and from Mexico each year. These Mexico-oriented migrants might constitute as much as 40 percent of the peak-season farmworkers in Coachella.

¹⁰ We refer to permanent houses as being “stick-built,” meaning they are built on-site and are not pre-manufactured. The term is commonly used in the area.

¹¹ *Housing Element*, County of Riverside, 2001, p. H222.

¹² This situation resulted, in part, from the California Employee Housing (Polanco) Act of 1992, which exempted agricultural housing from the conditional use permit process. Issuance of a conditional use permit usually involves a public hearing before a planning commission. It enables a city or county to consider essential or desirable uses of a given parcel of land that are not automatically allowed as a matter of right within a zoning district.

¹³ In this part of the ECV, where the elevation is near sea level, the water table is near the surface. This can lead to the intermingling of drinking water and sewage.

¹⁴ The language barrier also extends to the increasing numbers of Tarascans (an indigenous group from the Michoacán area) in the ECV who speak Purépecha (some speak a little Spanish). Problems have arisen not only at the clinics, but also at the schools where no Purépecha-speaking service delivery staff exist. There is an increasing demand for educators and outreach workers who speak Purépecha.

¹⁵ Though some providers in the ECV were unfamiliar with how *promotoras* function, a small circle of them understood that these educators helped introduce farmworkers to health care institutions and increased farmworkers’ awareness of services and programs. One provider noted: “People who live in the community and can reach the people and tell them of the services that exist—that is very needed.”

¹⁶ See Mines, R, Mullenax, N., and Saca, L. *The Binational Farmworker Health Survey*, Davis,

Calif: CIRS, 2001.

¹⁷ BCDEP, CHDP, CCS, and Emergency Medi-Cal are available for income-eligible individuals regardless of immigration status who can provide proof of a local address.

¹⁸ Several different strains of HPV increase the risk for cervical cancer (such as HPV-16, HPV-18, HPV-31, and HPV-45). Annual pap smear tests help screen women for cervical cancer and have contributed to 75 percent decrease in cervical cancer deaths in the United States since the mid-1950s. See “HPV Test Effective for Women with Abnormal Pap Smears, Cervical Cancer Vaccine in Development,” (2001), <http://www.imaginis.com/womenshealth/news/news2.26.01.asp>, accessed on May 6, 2002.

¹⁹ MISIP is a county program that supports the cost of medical services for persons not eligible for Medi-Cal and who have no source of payment for their care.

²⁰ To keep doctors in the region, some clinics have felt compelled to increase compensation by nearly 30 percent.

²¹ Yet some farmworkers’ experience with ECV health care yielded more positive views. One woman covered by Medi-Cal had a child with a bad case of herpes. The child spent eight days in a hospital and was treated with creams that cleared up the problem. Medi-Cal also covered the costs. She stated that she was very satisfied with the treatment. Another woman who qualified for Presumptive Medi-Cal while she was pregnant was also satisfied with the care she received. A third woman with breast cancer was very grateful for the support she got from BCEDP for a breast-removal operation and accompanying treatment. The program paid for all the costs.

²² In general, residents of the ECV are pleased when an operation works, but if it doesn’t, they often blame the doctor. One man who had a hand operation due to carpal tunnel syndrome said that the operation “left me worse off.” He thought that he received substandard treatment because he was a Workers’ Compensation patient.

APPENDIX: METHODS DETAILS

The report summarizes the opinions and facts given by the community of farmworkers and the community of professionals who deliver services to them. The purpose was to describe the community using its own voice and to get a sense of their perspectives and perceptions. The recommendations and observations reflect a consensus in the community as mediated by the researchers.

METHODOLOGICAL STEPS

The first step was to organize a telephone survey of the provider and service community. Separate protocols were designed for medical providers and for social and outreach workers. We conducted the survey in September 2000, allowing us to identify the main Coachella Valley neighborhoods where farmworkers live while describing in some detail the main programs that provide services to these farmworkers. The telephone inquiry, which involved conversations with about 30 people, did not allow for an understanding of the strengths and weaknesses of the service resources available to the farmworkers. And, of course, it did not allow for input from the farmworkers to identify their major health problems and to describe the main barriers they face in obtaining services.

Next, the team perfected a worker protocol and further improved the protocols to be used with providers and service delivery workers. In November, three interviewers along with the project director spent a week in Coachella interviewing workers. The sampling process attempted to focus on major networks of individuals from three areas. The towns near Jiquilpan, Michoacán were chosen as representative

of the interior Mestizo population. The town of Comicho was chosen as representative of a Tarascan (Purépecha-speaking) area. In addition, people from Mexicali were chosen since they were so numerous among the population of farmworkers. The sampling of individuals was not strictly limited to these areas but a large proportion was from each of these three. Also, we intentionally selected a sample of people of different ages, men and women, and people who were separated from and with their families.

In January and February, we returned to Coachella and interviewed a series of individuals, including providers and workers. We intentionally followed up on issues that the community (from all sectors) identified as crucial to farmworker health. As a result, we spoke to community organizers, aides to politicians, housing officials, and outreach workers of various kinds. We also were careful to sample all manner of health care providers—nurses, nurse practitioners, intake workers, accountants, doctors, and physician assistants. We were successful in obtaining interviews with some individuals in all the organizations considered to be the frontline groups delivering services to farmworkers.

With the fieldwork concluded in Coachella, we have continued to discuss and revise the protocols. It must be remembered that the purpose of the current data collection is to gather qualitative not quantitative information. We continue to develop hypotheses to test both in the field and vis-à-vis the CAWHS and BHFS data sets.

The next step was to import field notes (in Microsoft Word) to a qualitative text analysis software package (Atlas.ti). This process necessitated revising and editing

notes, as they may not be edited once imported into Atlas. This task created the opportunity to also review notes and extract contacts and leads for subsequent fieldwork in the subregion. Standards on the format of written notes were established.

In revising the protocols, new dimensions emerged to be queried in more detail, specifically questions relating to social structure and financial resources. These questions are being implemented in all the areas.

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

The AWHS team had a two-day training program for the field work staff before returning to the field. Protocols were reexamined and the possible coding schemes were reviewed. The examination of the field notes served to facilitate the iterative refinement of the protocols and the research design. The approach of this study involved open-ended questioning of interviewees with an emphasis on collecting details on the particular problems and issues important to the respondent, while balancing this with a systematic collection

of information across sites.

CODING

The interview data were placed in “text with carriage returns” format. These are called primary documents (each interview equals a primary document) and are considered the data source. A set of primary documents comprises a hermeneutic unit. Within a hermeneutic unit, subsets of primary documents can be grouped into families.

We created two hermeneutic (analysis) units, one for farmworkers and one for providers/outreach workers. The primary documents were coded using the code lists. We took approximately five primary documents and piloted them for coding. A consensus was reached on the final lists of codes (farmworkers and providers). Coding consisted of selecting a phrase, sentence, paragraph, or groups of paragraphs that represented a concept. The selected texts are called quotes. Multiple coding was allowed and has served to facilitate analysis of the data.

ANALYSIS

After the coding was completed, reports were generated showing the frequency of each code. Tables were generated to determine how often each code appeared in each primary document. The quotes associated with the codes were printed out to identify themes, patterns/relationships, dimensions of phenomena (valence), and offer contextual understanding. These reports on codes and their quotes were used to structure the reports for the AWHS. Feedback on these analyses was given to current field researchers, in order to further revise protocols and sampling.