

5-2018

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Beyond Borders: Accessing Healthcare for Migrant Farmworkers

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Spring '18

Keywords: migrant, healthcare, access, migration, farmworkers, labor, undocumented

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Abstract

This report provides a California case study of both the national and larger global issues associated with migrant farmworker healthcare. I chose to focus on the state of California because it has long been home to the largest number of immigrants in the United States and nearly 34 percent of California's labor force is comprised of immigrants. Furthermore, California is a perfect place to focus on migrant farmworkers specifically because of the thriving agricultural industry that is based in California, making it the number one producer and exporter of agriculture. For over 50 years, the men and women working in California's agriculture have helped make it the nation's number one producer and exporter of agricultural goods. The irony is that a majority of the workers who have helped the United States become the world's largest food exporter are foreign born, and as a result do not equally benefit from the country's success in which they have helped generate. Without this massive migrant labor force working in agriculture, the United States would not be able to maintain their status as the world's number one agricultural producer. California produces labor-intensive crops and the comparatively low wages for this work does not attract sufficient native-born labor from the urban center of California, therefore California's agricultural industry relies greatly on low wage immigrant labor. When immigrants arrive in the US, they are exposed to a healthcare system that differs from the system they are familiar with in their native countries. Navigating this new and intricate system is especially difficult for immigrants of low income and education who are likely to face economic and systemic barriers to care.

Introduction

My research focuses on the challenges faced by migrant farmworkers and their families in gaining access to healthcare. Although there are migrant healthcare policies and programs in place, they are not fully utilized by migrant farmworkers for a number of reasons that I will discuss. My research will examine these barriers and how they relate to greater systemic issues in order to evaluate the current systems in place as well as discuss the changes that are needed to provide better support for migrant farmworkers. Through my research and analysis of past and present programs and policies to help migrant farmworkers and their dependants, I will focus on the tremendous health risks that are involved with agricultural work. Finally, this study will reveal how these programs and policies fail to serve this vulnerable population and the adjustments that could be made to ensure that migrant farmworkers and their families are able to fully utilize the resources available to them. I will pose the question, how can existing healthcare programs for migrant farmworkers and their families be improved to increase program access and utilization? For this paper I will use the term “migrant farmworker” to include both migrant and seasonal farmworkers who can be defined as “an individual who is required to be absent from a permanent place of residence for the purpose of seeking remunerated employment in agricultural work” (“The Migrant”). This includes both documented and undocumented migrant laborers, primarily migrating from Mexico. According to the U.S. Department of Labor’s National Agricultural Workers Survey (NAWS), approximately 1.4 million out of the 2.3 million farm laborers the agricultural industry employs are migrant and seasonal farmworkers (Mehta et al., 2000). The well-being of the migrant farmworker population is extremely important not only because they deserve basic human rights globally just like every other human being but because they are an integral part of the world economy and their work provides families around the world with food and other commodities used to keep them healthy and well.

Literature Review

For this review I will start by providing a short history of labor migration into the United States beginning in the mid 1900's and how it has evolved since then. To follow, I will analyze literature that focuses on the aspect of community and visibility, variations in healthcare due to documentation status, child labor in agriculture and looking at the everyday lives of migrant farmworkers. My research will cover food insecurity and poverty among migrant farmworkers households and the unique health issues affecting migrant farmworkers and their families. Finally, I will analyze past and present programs that aim to give greater access to resources for migrant farmworkers. After highlighting the issues that contribute to health disparities among migrant workers and their limited access to proper healthcare, I will bring in the theory of structural racism and structural violence to explain how these issues can be alleviated in order to improve the lives of migrant workers globally.

Labor migration of Mexicans to the United States originated with the Bracero Program. Between 1942 and 1967, in attempts to fill the labor shortage in U.S. agriculture and industry, the United States signed the Mexican Farm Labor Agreement with Mexico which allowed millions of Mexican men to work in the United States on short-term, primarily agriculture, labor contracts. This program opened up migration routes into the United States and initiated seasonal or temporary work in the agricultural industry. Because of its proximity to the border, California was the principal destination for indigenous Mexican migrants (Ortiz 2014). Following the Bracero Program, migration into the United States increased greatly after the U.S. Congress passed the Immigration Reform and Control Act (IRCA), which allowed millions of unauthorized immigrants to apply for legal status as well as made it illegal for an employer to hire an unauthorized immigrant. Although this was meant to put a stop to undocumented

migration, it resulted in thousands more immigrants coming to the United States. Following this influx of migration, immigration policy within the U.S. became increasingly more restrictive as did border control efforts. In 1996, the U.S. Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA), which increased the number of reasons for the deportation of migrants, increased border security and made it more difficult for unauthorized immigrants to gain legal status while in the U.S (Ortiz 2014). This paradoxically led many unauthorized immigrants to stay in the U.S. because of strict and dangerous border crossing while forcing them to remain unauthorized because of the increased difficulty in gaining legal status. Mexican immigrants represent the largest immigrant group residing in the United States, however only 22% of them are US citizens. “Among non-citizen immigrants from Mexico, 2.3 million are lawful permanent residents (25%) and the remaining 6.9 million are undocumented” (Vargas Bustamante et al., 2012). This study will later discuss the disparities in healthcare access and utilization among undocumented and documented immigrants in the US.

Over time we have seen transformations in labor migration. Labor migration originally consisted of an individual migrating for work and sending home remittances to their family. However, due to greater militarization of borders making the task of crossing the border more dangerous, costly and difficult, migration is more commonly done as a family unit (Gonzales 2017). Prior to the 1980s, most migrants were seasonal migrant workers and would travel back home to their families more frequently, however since then it has become significantly harder for migrants to cross borders. This has created a shift in migrants traveling alone for work, to migrant workers bringing along their spouses and children for long-term stays. This has resulted in the increased health risks and educational challenges of many migrant farmworkers and their families.

Along with migration comes many adaptations and changes to the daily lives of migrants and their families. The concept of community is extremely prevalent in many studies of migration, from how migrants are able to form communities within their jobs that help them transition to a new country while still being able to maintain their cultural identity, to how migrant children are able to transition into society by being incorporated into a community through schooling. This kind of inclusion in a community is important for migrant families to transition into their new environment and shows why education for migrant children is so vital for forming personal connections and relationships with those around them as they grow up. This trend of community in literature on migrant populations is brought up in an article on the impacts that invisibility has on migrant farmworkers, where the authors explain a case study in Georgia that illustrates, “how isolation from family and community, as well as invisibility within institutions, affect the health and well-being of migrant farmworkers in southeastern Georgia” (Bail 2012). This study focuses on migrant farmworkers in the Southeastern United States and how their invisibility within institutions such as the educational system, health care, social services and domestic violence centers as well as their isolation from communities contribute to the decline of their health. Bustamante et al. (2012) suggests that immigrants with strong social networks have a greater chance of getting the resources and services needed for their health. “Recent evidence suggests that immigrants with strong social networks in the US benefit from better information about healthcare services. Ultimately, better information leads to increased healthcare access and utilization” (Bustamante et al., 2012). This shows how increased visibility of immigrants among their society and stronger social networks can lead to increased utilization and access of healthcare and social services available to them.

In the article “Variations in Healthcare Access and Utilization Among Mexican Immigrants: The Role of Documentation Status”, the authors conduct studies using five variables commonly used to measure healthcare access and utilization in order to identify differences in healthcare access and utilization among Mexican immigrants according to documentation status (Bustamante et al., 2012). The variables used to determine this included the following: “Healthcare access measures include: i) whether an individual had a usual place to go when sick, ii) whether an individual experienced a delay in obtaining healthcare, and iii) whether an individual experienced a delay in receiving a prescription drug. The health utilization measures identify whether an individual had at least one physician visit during the previous year and whether an individual had at least one emergency department (ED) visit during the previous year” (Bustamante et al., 2012). The authors concluded that “approximately 88% of the disparities between undocumented and documented immigrants from Mexico can be traced to socioeconomic and demographic characteristics such as sex, marital status, education, poverty status, health insurance coverage, time in the US and English proficiency” (Bustamante et al., 2012). Furthermore, based on their findings they suggest that if all undocumented immigrants from Mexico shared the same characteristics of the documented population, they would enjoy a 27% higher probability of having a doctor visit and a 35% increased probability of having a usual source of care. Other significant determinants of this disparity are deportation fears, peer effects, safety net availability and lack of familiarity with the US healthcare system that act as a deterrent of healthcare access and utilization among undocumented immigrants (Bustamante et al., 2012).

Truly understanding the everyday lives of migrant farmworkers and the obstacles and difficulties they face day-to-day is a crucial step in helping them and their family access the

healthcare and social services they need. Multiple books and publications have given the rest of the world insights into the everyday lives of migrant workers such as *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States* which follows the ethnographic research of author Seth Holmes (2014) who travels with and works alongside migrant farmworkers where he discovers how anti-immigrant sentiment and racism undermine healthcare for these individuals. Holmes uses his work to outline the structural violence that he claims needs to be addressed in order to alter policies and realities for migrant workers. He writes, “I hope that understanding the mechanisms by which certain classes of people become written off and social inequalities become taken for granted will play a part in undoing these very mechanisms and the structures of which they are a part” (Holmes 2014, p. 29).

Another book that helps to outline the struggles and hardships faced by immigrant youth, especially in terms of education, employment and healthcare is *Lives in Limbo: Undocumented and Coming of Age in America* by Roberto Gonzales (2016). This ethnographic novel uses qualitative research through a twelve-year study following 150 undocumented young adults in Los Angeles, California in which the author conducts interviews of the youth being studied, allowing him to get a first-hand account of the troubles and obstacles undocumented migrant youth face growing up in America. Through his study he highlighted the hardships these undocumented youth face everyday living under strict US immigration policies that infringe on their abilities to integrate into their local communities and receive the same support and resources as their peers.

Within the international literature on health issues of migrant farmworkers, multiple sources point out the prominence of food insecurity within these households and the impacts they have on the workers and their family. In her article “The Household Food Insecurity and Health

Outcomes of U.S.–Mexico Border Migrant and Seasonal Farmworkers”, the author defines food insecurity as “a limited or uncertain availability of food, or uncertain ability to acquire acceptable foods in socially acceptable ways due to restricted financial resources” (Weigel 2007). In a study done on food insecurity in 100 households of migrant and seasonal farmworkers living on the U.S.-Mexico border, it was found that 82% of the households were affected by food insecurity (Weigel 2007). Claire Fitch (2017) emphasizes the effects that this food insecurity has on the children within these households, making the argument that food insecurity among children has shown to have psychological consequences such as depression, hyperactivity, anxiety and inattention which can have a significant impact on their education and ability to succeed in school.

It is evident in many cases how healthcare is especially important for the children of migrant farmworkers because children of migrant farmworkers often live close to the farms in which their parents work, and are exposed to harmful chemicals either brought home on the clothes of their farmworker parents, or by living in close proximity to the farms where pesticides are used weekly. Therefore the children of migrant workers often share common risks and burdens associated with agricultural work. In the book *Pesticides in the diets of infants and children* (“National Research Council” 1993) the authors trace the impact of the wide use of pesticides in agriculture in the United States and describe the unique conditions in which pesticides affect the health of infants and children in the homes of farmworkers. Another study called CHAMACOS, meaning “little children” in Spanish, collected 17 years of data that tracked children’s developments and environmental exposure in a Latino farmworker community. Starting in 1999, the study enrolled a number of pregnant women living in California’s Salinas Valley, one of the most productive agricultural regions in the United States. Researchers

followed the women and their families for 17 years conducting tests every 1-2 years that measured exposure to pesticides and other chemicals and the adverse effects they had on the children's growth, health and development. This study shows the impacts of pesticides on children's brain development and respiratory health, highlighting the specific health risks associated with chemically exposed populations such as farmworkers and their families ("CHAMACOS").

One article claims that children of migrant farmworkers are at a higher risk for health issues due to their status as well as environment, stating that "Primary care practitioners have rated Mexican-American migrant children 2 to 3 times more likely to have poor or fair health as opposed to good or excellent health, compared with non-migrant children" (Nichols 2014). Not only are migrant children at higher health risks because of their environment, but a large number of migrant adolescents under the age of eighteen work in agriculture under the same grueling conditions as adult farmworkers. "Each year an estimated 128,000 hired adolescent farmworkers aged 14-17 years are employed in US crop agriculture" (Vela 2001). Vela argues that adolescent farmworkers are an extremely vulnerable group because they are mainly single males who have traveled long distances for work and most lack adult guardianship and any kind of familiar support.

Due to their vulnerable status and young age, most child laborers live in households that lack a telephone or mailing address which are often used for government surveys and data collection, therefore it is difficult to count how many children under the age of 18 are working in agriculture. Human Rights Watch has estimated that hundreds of thousands of children are working as hired laborers in agriculture in the United States. In 2006, farm operators reported directly hiring 211,588 children under age 18 ("Fields"). Considering that many children

working in US agriculture are unauthorized workers, there are considerably more children than accounted for. US laws for underage labor is surprisingly less rigid in agriculture than in other sectors despite the health risks that are associated with agricultural work. “Under the law, on small farms with parental permission, outside of school hours, there is no minimum age for workers. Children ages 12 and 13 can work for any size farm with their parent’s consent outside of school hours; children 14 and 15 can work on any size farm without parental consent outside of school hours; there are no restrictions on employing children ages 16 and older, including in hazardous agricultural occupations” (“Fields”). However in nonagricultural sectors, employment of children under age 14 is prohibited.

This showcases the importance of accessible healthcare for not only migrant farmworkers, but their families as well. Because of the extremely low wages farmworkers receive, they are known to be one of the most vulnerable populations affected by poverty. “Poverty among farmworkers is more than double that of all wage and salary employees in the United States” (“Fields”). This has a major impact on the involvement of child labor in the agricultural industry. Many parents report sending their children to work for a variety of reasons surrounding financial insecurities such as difficulty meeting basic household expenses and inability to afford child care while they are at work. Due to the extreme poverty of migrant farmworkers and the relatively lenient laws on underage labor in U.S. agriculture, over sixty percent of all child laborers worldwide work in agriculture (“Fields”). Another important factor specific to agricultural work that encourages the use of child labor is the piece rate system that many farm operators employ. This system replaces hourly rates by paying workers by the amount of product they are able to harvest. This system is appealing to employers because it is

said to incentivize productivity, however it often results in children working alongside their parents in order to harvest more and receive higher wages in exchange.

Much of the literature on the topic of migrant healthcare does offer solutions to these issues in the form of policies and programs. One article includes a comprehensive study and data collection of migrant farmworkers' children who are served by the Farm Worker Family Health Program (FWFHP) in Moultrie, Georgia and the effectiveness this program has had on its recipients. It uses this data to compare the health issues of migrant children from the ages of 0 to 16 to children in the same age range in both the United States and Mexico. The results from this study showed that there was a higher prevalence of obesity and elevated blood pressure among the children in the FWFHP than in all other comparison groups. Further, the author acknowledges that although this program is intended to increase access to healthcare among migrant populations, there are still low utilization rates, which is common among almost all programs created to help migrants. The author states, "There are approximately 400 federally authorized sites for migrant health care; however, these sites only serve 12% to 15% of the migrant population" (Nichols 2014). This shows that there are an increasing amount of resources for migrant farmworkers and their families, however, these resources are not being fully utilized for many reasons such as lack of knowledge of available resources, fear of deportation or job loss, language barriers, and accessibility issues due to limited transportation and lack of child care. The issue is not providing the resources, but providing safe and secure personal assistance to help these farmworkers obtain the services they need while navigating their busy work and family schedule. This could make it easier for them to first, understand what resources are available and how to use them and second, to make these resources easier for the workers to access. This could be as simple as these organizations sending out bilingual people to these

communities where most farmworkers work and live and informing them of their healthcare options, and guiding them through any paperwork needed while translating along the way. It is important that these farmworkers are not only given resources but are felt that they are represented and acknowledged in these institutions and wider society. Many migrant farmworkers deal with a lack of social support in their lives because most have left all of their friends and family members behind in their pursuit of work and a better life for their family. What was once their support system in times of illness (having family members to take care of them or pick them up from hospital visits), or childcare (having family members or friends take care of their children while they are at work or help pick them up or drop them off at school) has vanished due to their migration, leaving them to take on the burdens and stress of the labor intensive and tiring lives of migrant farmworkers with little to no social support.

Data and Methods

Most of the literature on migrant farmworkers relied on qualitative methods to collect data on the migrant farmworker population. However there are many issues in getting complete data on vulnerable populations such as migrants because many do not have legal status in the country they are working in and therefore are not represented or recognized in many surveys or government data.

Many articles had incorporated qualitative interviews to gain insight into the troubles and stresses that migrant workers and their families go through on a daily basis and to assess the effectiveness or ineffectiveness of health policies or programs among migrants. Others use quantitative methods to gather a broader amount of data on how many migrants are working in the agriculture industry, how many have health issues, how many have children etc. However, this quantitative data collection is a more difficult approach to vulnerable populations such as

migrant workers because of their constant mobility for work and the fact that many of them are not in the state system because of their lack of identification and legality, making it difficult to get accurate data that represent the majority of the migrant worker population.

Some of the most accurate data on current U.S. farmworker populations comes from the National Agricultural Workers Survey (NAWS) which conducts a national random survey sample administered by the U.S. Department of Labor that aims to collect demographic, employment and health information of workers in crop or crop-related work regardless of immigration status. Although there are still limiting factors in collecting accurate and representative data on this population, for example, the NAWS does not include workers who are working under an H-2A visa (a temporary-employment visa for foreign agricultural workers) which constitutes a large number of agricultural workers who are being affected the most (Fitch 2017).

One article had collected data on food insecurity among migrant and seasonal farmworkers using the “U.S. Food Security Scale, California Agricultural Workers Health Survey, and objective anthropometric, clinical and biochemical indicators” which resulted in evidence suggesting that food insecurity had an adverse effect on health among migrant farmworkers and their families (Weigel 2007). Another article titled “The Impact of Invisibility on the Health of Migrant Farmworkers in the Southeastern United States: A Case Study from Georgia” used an ethnographic approach where the authors conducted participant observation research to create a case study in Georgia that helps illustrate the impact that invisibility within institutions has on migrant farmworkers in terms of their access to healthcare and education.

The methodology that I use in my research is qualitative methods. I rely on quantitative data from secondary sources to reference and help highlight and compare health issues of

migrant farmworkers. I am using systematic bibliographic research to gather information on migrant farmworkers and the health issues surrounding them and I use both scholarly articles and government documents to address policies and programs related to migrant farmworkers.

Furthermore, I use both a diachronic and synchronic analysis of my research. A diachronic analysis is used to trace the historical background of labor migration and a synchronic analysis is used to compare current issues in migrant farmworkers healthcare in California to similar issues both nationally and internationally. I'm using secondary sources in which a majority of the sources use primary data in the forms of ethnographic research, surveys, or personal experience. Through this methodology I gathered information that allowed me to explore how current programs targeting migrant farmworkers could be adjusted to increase utilization of resources among migrant farmworkers and their families.

Findings and Analysis

Many states have made steps towards this issue by starting on a local level, but as migrant farmworkers continue to move to where work is available, they lack effectiveness, stability and regularity in their access to healthcare and child services such as education as they move. For the purpose of understanding studies and programs directed at these communities it is important to know the difference between seasonal and migrant farmworkers. The U.S. Department of Housing and Urban Development makes the distinction between migrant and seasonal farmworkers by defining a seasonal farmworker as remaining "in the same housing, though he/she may travel to different employers over a wide geographical area and work different crops during a season" and a migrant worker who "will relocate his/her place of residence during the course of a growing season in order to follow the crops" ("Common Questions"). This distinction is important when creating policies and programs that will be

effective and useful to migrant farmworkers and their families throughout their duration of time in agricultural work as they continue to migrate. This is a prominent factor to why many resources for migrant families are not being utilized because the processes they have to go through each time they move to reapply for Medicaid and other programs is too time consuming and difficult to do each time they relocate. This is why it is important to stress the need to implement these policies and programs on a national level so that migrant workers will be able to maintain their access to healthcare and education services as they and their families move for work.

Not only is there a need to eliminate the language barrier by providing language assistance, additionally programs need to acknowledge the cultural differences within the populations they serve and how these differences affect the utilization of their services. A qualitative study done in 2008 assessing the migrant health volunteer programmes that were implemented in two provinces in Thailand with the highest concentration of migrant workers found that, “attitudes towards the programme were positive and the migrants recognized the benefit of these volunteers who spoke the same dialect and shared the same culture” (Tangcharoensathien 2016). This study helps to show that restructuring these programs to be more culturally inclusive of the population they are serving by offering volunteers who spoke the same language and shared the same culture as the migrants resulted in the migrants’ health awareness and service uptake. Rather than pushing migrants to fully assimilate in order to access necessary services, Rebecca J. Hester (2015) suggests that there is a need for cultural competence training in healthcare fields to better assist migrant workers by understanding cultural differences and how to provide appropriate services that are considerate of the patient’s culture. The implementation of cultural competency training into healthcare services can have

positive effects in increasing the utilization of services by migrant farmworkers. This highlights the necessity for healthcare workers to take into consideration the cultural variety within the population they are serving and the specific needs of the patients based on these differences.

One organization that focuses on helping established healthcare programs incorporate cultural competence into their services is Migrant Clinicians Network. Migrant Clinicians Network is a global nonprofit organization that works with clinicians in Federally Qualified Health Centers (FQHCs) and other healthcare delivery sites with the purpose of reducing health disparities and increasing access within these programs for migrant farmworkers and other mobile underserved populations. The organization is comprised of researchers, academics, policy makers and frontline clinicians who work together to improve migrant health on a global level. One of the main aspects they focus on is the continuity of care for their mobile patients, which is extremely crucial for certain types of migrant farmworkers such as “follow the crop” and “seasonal” laborers that often move for available work.

Finally, documentation status is a major contributor to the disparity within healthcare among immigrants in the United States. Significant disparities in healthcare exist among Mexican immigrants, with undocumented immigrants facing a lower likelihood of having a doctor visit and a usual source of care (Bustamante 2012). The undocumented status of immigrants leads to a lower utilization of doctor visits and access to a usual source of care. This is primarily due to certain idiosyncratic factors such as fear of deportation and lack of familiarity with the US healthcare system. Since many migrant farmworkers in the US are undocumented Mexican immigrants, this disparity is detrimental considering the unique health risks associated with farm labor.

Theoretical Framework

There are many theories that have been applied to labor migration from neoclassical and world systems theory to more current theories such as dual labor market theory and the new economics of international labor migration theory. These all have worked to assess the causes and initiation of international migration but few have discussed the link between these causes of migration and the subsequent effects it has on the health of migrant workers. One article critiques the use of neoclassical theory in explaining labor migration, arguing that emigration decisions are no longer being made on an individual level but instead among families and households because members of migrant families have to act in common in order to maximize their income and minimize their risks (Porumbescu 2015). Another article by Alexandre Abreu (2012) addresses the issues with the new economics of international labor migration theory claiming to be a middle ground between neoclassical theory and historical-structural approaches to migration. Abreu rejects this classification of the new economics of international labor migration theory by stating that it is simply a ‘reworked’ version of neoclassical theory in the way that it ultimately attempts to “advance the fundamental tenets of neoclassical economics” (Abreu 2012, p. 1). These theories help to explain some of the issues associated with immigration, however they fall short in providing explanation for the specific problems faced by migrant farmworkers in their attempts to access quality, comprehensive healthcare.

My research on migrant farmworkers and their families’ access to healthcare aims to analyze certain programs and policies and their direct effects on the utilization and access of healthcare among migrant farmworker populations. The literature on this subject suggests that even with continuously new program and policy implementations, there are still discrepancies within healthcare that exists. This led me to ask the question, “how can existing healthcare programs for migrant farmworkers and their families be improved to increase program access

and utilization?” and further, what are the underlying issues that are contributing to what seems to be an impenetrable barrier between migrant farmworkers and comprehensive and accessible healthcare? To attempt to find an answer to these questions and further, possible solutions to this issue, I will be analyzing acculturation theory, both its strengths and weaknesses, and how the theory of structural racism and structural violence can be applied to explain the shortcomings of acculturation theory and give greater insight into the root of this issue.

Acculturation is the process by which individuals adopt the attitudes, values, customs, beliefs, and behaviors of another culture (Bail 2012). This theory has been used over time to address migrants and the issues they face. It has further been used specifically to address migrant health issues because of the certain barriers to accessing healthcare that is claimed to be a result from lack of assimilation. However, the process of acculturation can result in both advantages and disadvantages in migrant’s overall health. The theory of acculturation suggests that migrants are able to succeed when they adopt the practices from their host country in place of those from their home country. This theory urges me to contest the idea that migrants, in order to gain equal access and resources to healthcare, need to relinquish some of their culture through the strategic act of acculturation. One of the main obstacles that migrant farmworkers face when attempting to access healthcare is the language barrier that prevents them from fully understanding what resources are available to them and how to go about accessing them. This is where the process of acculturation can benefit migrant farmworkers’ access to healthcare.

However, since acculturation relies on migrants to relinquish some of their culture in the process, this can have adverse effects on their mental health. Furthermore, acculturation theory is only useful to migrant farmworkers who take permanent residence in their host country. But for most migrant farmworkers, such as follow the crop migrants, those who move from farm to farm

based on season, and shuttle migrants, those who go back and forth from US to Mexico, acculturation does not prove to be a useful tool (“Characteristics”). According to Hansen, “About two-thirds of migrant and seasonal farmworkers are “shuttle migrants” who travel from a home base (either inside or outside of the United States) to a specific destination for seasonal employment in agriculture. The remaining one-third follow crops for employment and move from place to place, usually along predetermined migratory streams along the Atlantic seaboard or the West Coast, or through the midwestern states and Texas” (Hansen 2003). Because migrant and seasonal farmworkers are a predominantly mobile population, the act of assimilating to their new environment each time they migrate can be extremely exhausting and not worthwhile.

Another issue in the use of acculturation theory that is raised is the concept of recognition (Bail 2012). In order for integration of migrants into their new host country to be effective, there needs to be a mutual recognition of the other as an equal. Citizens are considered to be recognized members of their state that are entitled to certain rights and protection. Non-citizens, which include undocumented workers, are therefore not recognized, making their integration a nearly impossible task. “All social integration depends on reliable forms of mutual recognition...which can be regarded as the engine of social change” (Foster, 245). This mutual recognition is a necessary first step to ensuring migrants proper access to healthcare. There are, however, many social and political boundaries that affect the recognition of migrant workers, often hindering their ability to integrate into their new society. “Nevertheless, the political desire to create boundaries between foreigners and full citizens, especially with respect to limited resources, such that health care is uneasily juxtaposed to the economic need for the productive migrant labor that non-citizens provide” (Bail 2012). This shows how states have an economic interest in the health of their workers. However, this political desire to create boundaries between

foreigners and full citizens that the author states is what I argue is the main contributing factor behind the barrier between migrant farmworkers and accessible healthcare.

The formation of this cultural barrier can be explained using the theory of structural racism, coined by W. E. B. Dubois. Keleher and Lawrence (2004) define structural racism in the U.S. as “the normalization and legitimization of an array of dynamics – historical, cultural, institutional and interpersonal – that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color.” They label the key indicators of structural racism as “inequalities in power, access, opportunities, treatment, and policy impacts and outcomes, whether they are intentional or not” (Keleher and Lawrence 2004). Immigration policy is a form of structural racism that has been proven to have an impact on health disparities, especially within the United States where immigration policy is becoming increasingly stricter over time. Some immigration policies have impacted immigrants’ access to healthcare and other social services, both directly and indirectly. For example, the Deficit Reduction Act of 2005 required Medicaid applicants to provide documentation of citizenship, which subsequently resulted in a decrease in insurance coverage among noncitizens (Gee 2011). Likewise, the 2010 Affordable Care Act continues to exclude undocumented immigrants from receiving any coverage and restricts certain services to documented immigrants. In addition, the Affordable Care Act retained tight restrictions on immigrants’ eligibility to Medicaid and Children’s Health Insurance Program (CHIP) through the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, which prohibited undocumented immigrants from accessing most federally-funded insurance programs (Parmet 2017). With the election of President Trump and anti-immigrant sentiment surrounding his presidency, the Republican effort to repeal and replace the Affordable Care Act will most likely result in even more restrictive access to health and social services for

immigrants, increasing the number of uninsured immigrants in the United States. Policies that promote increased state involvement in immigration enforcement creates a climate a fear among immigrants that can result in reluctance to access certain public services available to them.

Some of the major public programs created to support low-income families such as Medicaid and the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance to Needy Families (TANF) continue to fall short in providing adequate health care to migrant farmworkers and their families because of a variety of barriers immigrants face in accessing health and social services. These barriers include not only cultural and language barriers but strict program eligibility requirements that exclude many undocumented immigrants from receiving any coverage at all. These extremely rigid eligibility requirements reflects the anti-immigration sentiment in the United States that perpetuates the structural racism that inhibits migrant workers from receiving the healthcare and social services they need.

To better address the implications of structural racism on migrant farmworkers and their health, I will focus on the intersection of structural racism and structural violence experienced by migrant workers. Structural violence can be defined as “social arrangements that systematically bring subordinated and disadvantaged groups into harm’s way and put them at risk for various forms of suffering.” Through anthropological research, this suffering can be seen as originating from political-economic processes, social structures and cultural ideologies (Benson et al., 2008). The structural violence endured by farmworkers in the United States can be seen in their insufficiently low wages, endemic poverty, occupational health risks, social stigma, fear of deportation and limited access to health and social services. Agriculture is one of the most hazardous occupations in the United States. With that being said, the risks associated with

agricultural work is still highly underestimated because of how significant the underreporting of associated medical conditions are due to their limited access to medical services and most commonly fear of lost job or wages (Hansen & Donohoe 2003). These forms of structural violence are embedded in long-standing social structures that continue to determine the livelihood of migrant farmworkers.

The unequal distribution of citizenship is another form of structural violence because citizenship is a major determinant to a person's access to certain services and resources needed to not only sustain but improve quality of life. By limiting citizenship to certain people, a boundary is drawn between groups of people that categorize one side as belonging and the other side as "other" or outside of the larger community. Benson (2008) claims that "structural violence is often perpetuated on the basis of visibility", which can be seen in government programs and policies that separate documented from undocumented, allowing the suffering and harm of those undocumented to be ignored because of their invisibility in the greater social structure. The anti-immigrant sentiment that views undocumented immigrants as a threat to US nationalism influences public perception of immigrants that labels them as outsiders and therefore strategically limiting ethical responsiveness of both the state and its citizens. Being in a position of power and authority, the US government is able to shape discourse around immigration by labeling immigrants as a threat to nationalism, while completely disregarding the economic dependence the US has on low wage labor, specifically provided by Mexicans and other immigrants. Inequality is enforced in laws and policies that naturalize differences in status, either legal or illegal, and it is this status that becomes a justification for mistreatment.

The structural violence in farm labor stems from both economic policies and poor government regulation of farm labor conditions (Benson 2008). Benson (2008) claims that the

issue lies within the narrow understanding of immigration that overlooks the macro level of economic liberalization that drives transnational labor migration and applies downward pressure on farms. This pressure on farms to maintain low prices and be competitive in their market results in noncompliance for growers, which subsequently results in the abuse and neglect of farmworkers. In order to better approach this issue, the author suggests a collaborative effort from both farm labor and management to improve economic security among growers along with working conditions for laborers (Benson 2008).

This is a case study focusing on migrant farmworkers' access to healthcare in the United States, however hopefully it has helped to illustrate the larger issue of health disparities among citizen and noncitizens within the United States and the negative impacts it has historically had on immigrant health and well being. I argue that these health disparities do not surface from lack of available resources or failure to assimilate, but are a direct impact of the structural racism and structural violence that is inherent in immigration policy and discourse surrounding immigration that shapes the ideals and actions of the society in which these immigrants reside.

Conclusion

Since globalization is inherently linked with population mobility, it is clear that as time goes on, more people will continue to migrate. This requires a collaborative approach to the issue of migrant healthcare by urging decision makers in the health and migration sectors and policy makers to work together to address healthcare disparities. The health of the people needs to be at the forefront of discussions and policy implementations regarding migration. The problem with many migration health policies is that they primarily exist in isolation at state levels. Because globalization has shaped immigration so drastically, there is an undeniable need for global health protection agreements if we wish to effectively approach issues of health disparities among

migrant populations in the near future. Furthermore, there is a large discrepancy between those providing health services to migrant and those making policies regarding migrants' entitlements to these services. Migrant farmworkers are just one of many diverse migrant groups that have unique health issues associated with their status and type of work they are in. Therefore, these policies need to take into account the diversity within migrant populations and the specific health needs associated with certain groups in order to have a greater impact on migrant health globally. Since the early 1990s, Migrant workers have been an extremely prominent and growing population in the United States. Understanding healthcare access and utilization in this increasing population is not only important, but also relevant for both healthcare and immigrant reform.

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