

# Health Outcomes in a Binational Context

Discussion of three CIRS studies gives:

Insights into the demographic and migration patterns of farmworkers

Reveals many of the main health problems facing farmworkers

But, the most important finding was that the Mexican farmworkers' most severe health problem is an extreme cultural clash

The importance of this clash occurred to me while doing binational work—hard to see the clash on one side of the border or the other

# Methods: 3 distinct studies with quite different insights

California Agricultural Worker Health Survey (CAWHS)

The Binational Farmworkers Health Survey (the BFHS)

The Agricultural Workers Health Study (the AWHS)

All took questions from the mother survey, the National Agricultural Workers Survey or NAWS

# CAWHS—household sample

CAWHS done in seven small rural towns dispersed among California's major farm areas

Chosen in each town by randomly selecting dwellings within the communities

About 1,000 farmworkers gave us self-reported data, 2/3rds had a physical examination—best from the CAWHS

Physical examination gave us insights into the principal health outcomes of current CA farmworkers



**Demographics** of studies show us who farmworkers are:

Median age is 34, its median schooling is about 6 years

About half are married with children

About half of the spouses and children in Mexico

Very few ever learn to speak English well

From ethnographic work--there are very large pockets of indigenous speakers.

## **BFHS quite different—NETWORK SAMPLING.**

7 villages in southern Zacatecas : sample based on farmworker  
Universe lists in each town

Interviewed in the village (300) or in a select few settlement areas  
in the United States (150).

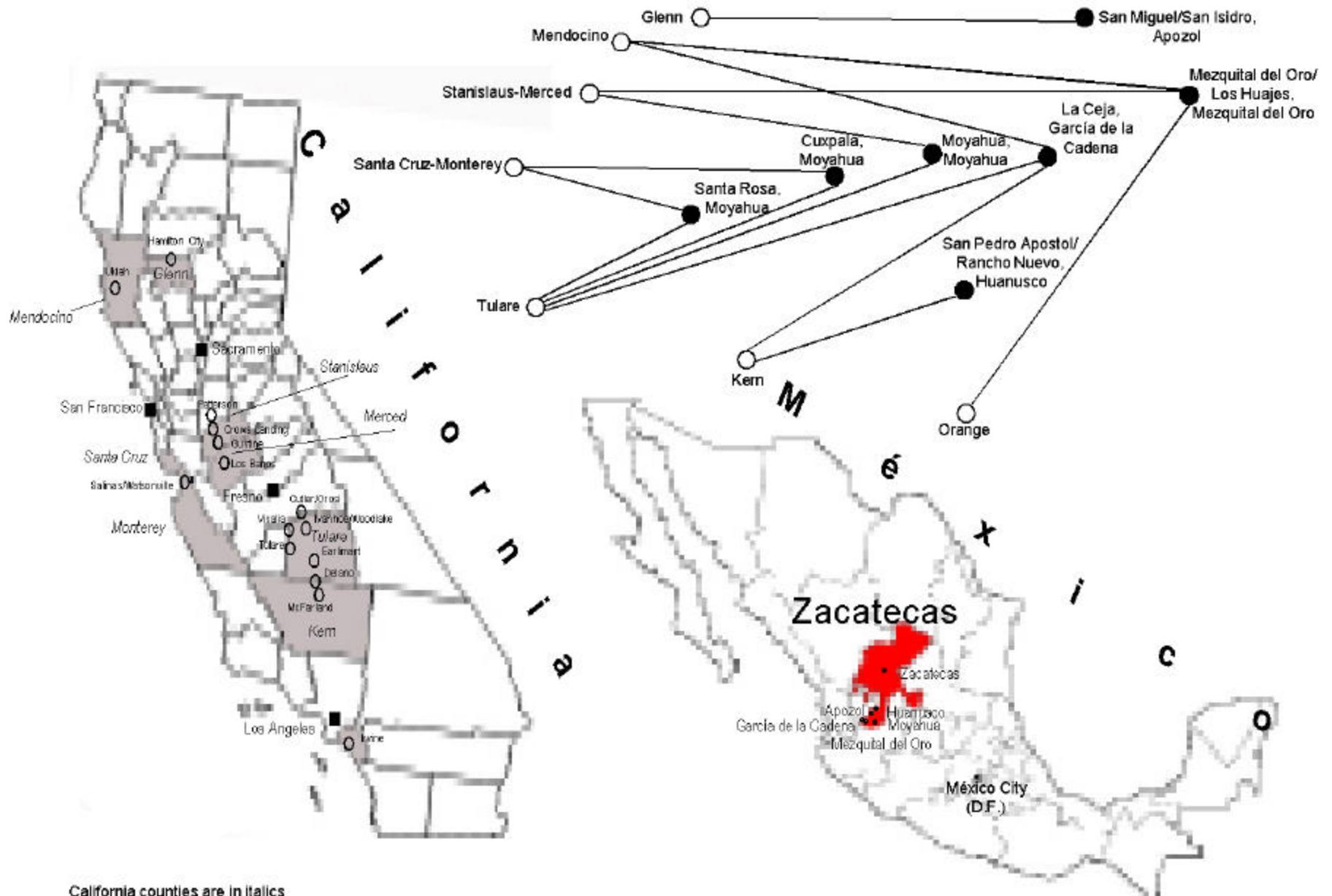
### **Advantages:**

- BFHS collected data on ex-farmworkers and those returned to Mexico.
- Better data, higher trust built--people in the comfortable surroundings
- We saw how mature, well-rooted networks interact with the U.S. system.
- Observe health care providers and health care system in rural Mexico

# Map of Zacatecas Sending Sites and California Filial Communities

Filial Community Counties

Sending Sites (Village) & Municipalities



California counties are in italics

AWHS occurred in six farmworker towns in California.

Each region is a natural commuting distance area for farmworkers with common health system

In-depth ethnographic interviews done on coast, Desert, Central Valley

Purposive selection of interviewees--done in an open-ended manner with all stakeholders

Worker interviewees within binational farmworker networks; the provider interviewees also found by referrals from previous interviewees.

Tape-recorded, much was transcribed, interviews coded using an ethnographic software package

Advantage was to help understand how and why problems exist in a local CA context.

1. Diaspora from a given sending point in Mexico concentrated in few receiving places in the US (see Map)

Cuxpala to Cutler, San Pedro to Earlimart area, Santa Rosa to Watsonville/Salinas

2. the extreme back and forth nature of the mature migratory networks (see Proportion)

We did a life labor history on the 467 respondents. Every move recorded from age 16 on

Over half or 54% is spent in the United States but great variation;

Mesquital del Oro, average only 41% in US; in Santa Rosa over two-thirds

In Mesquital, children still being born in the village, in Santa Rosa, born in the US. Santa Rosa is a rest and recreation area for migrants

## Proportion of Adult Life Spent in the U.S. by Village (BFHS)

Town	Percent Adult Life in the U.S.	Sample Size
Santa Rosa	68	57
Cuxpala	67	63
Moyahua	60	58
San Miguel/San Isidro	53	81
La Ceja	51	41
San Pedro/Rancho Nuevo	45	59
Mesquital/Los Huajes	41	108
All Towns	54	467

Again, we did three studies—the CAWHS sampled in the seven California towns gave us physical exam data on current farmworkers

The BFHS focused on the binational networks gave us insight into the binational context and data on ex-farmworkers

The AWHS captured the farmworker health dilemma in a local California context

Now, before I outline what we consider the cultural obstacles facing the Mexican farmworkers, I will highlight 3 areas of health findings of the studies—survey and ethnographic findings

Access, Chronic illnesses and Job-related illnesses.

All studies show little insurance and low doctors' visits; CAWHS 70% , in the BFHS 60% report no insurance

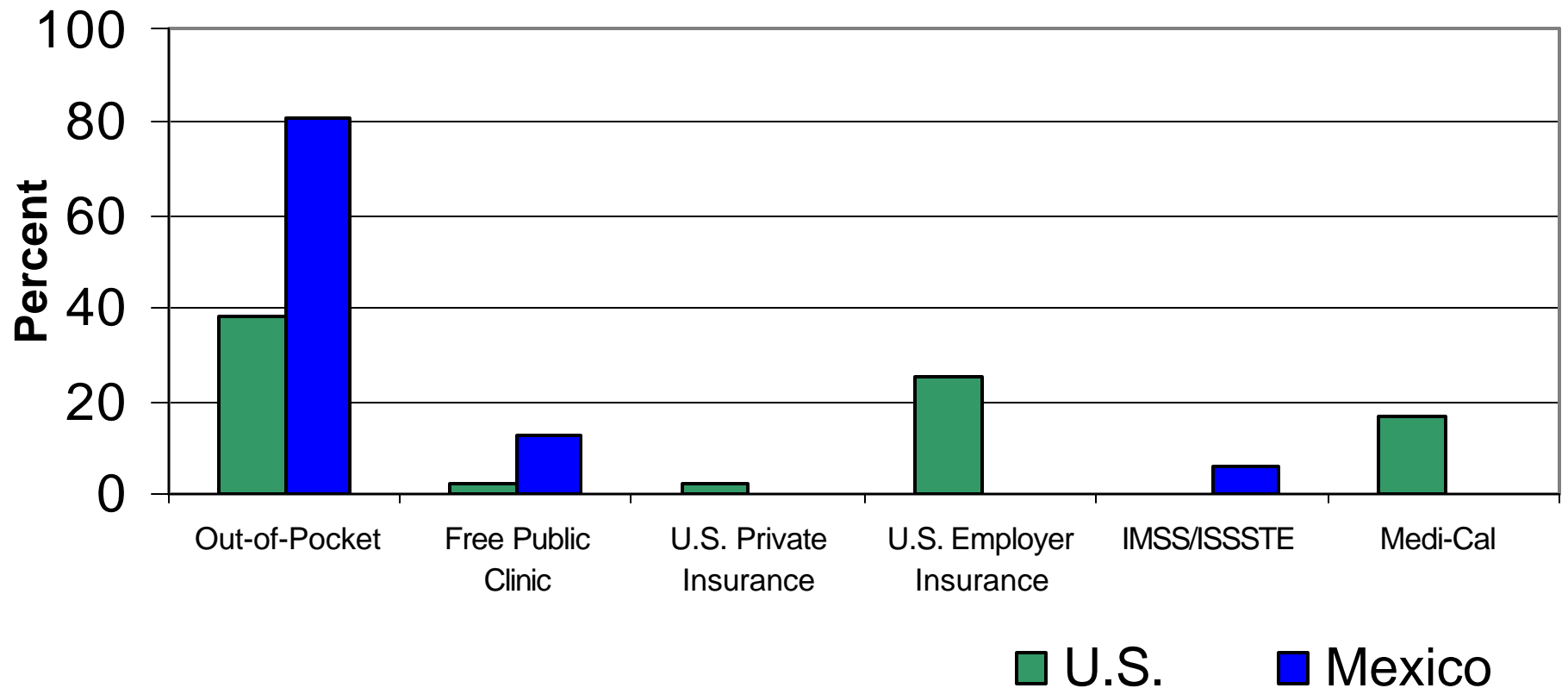
Those with insurance may not use it due to high co-pays and restricted coverages (see Method).

The ethnographic work recorded repeated complaints from workers about the ineffectiveness of insurance

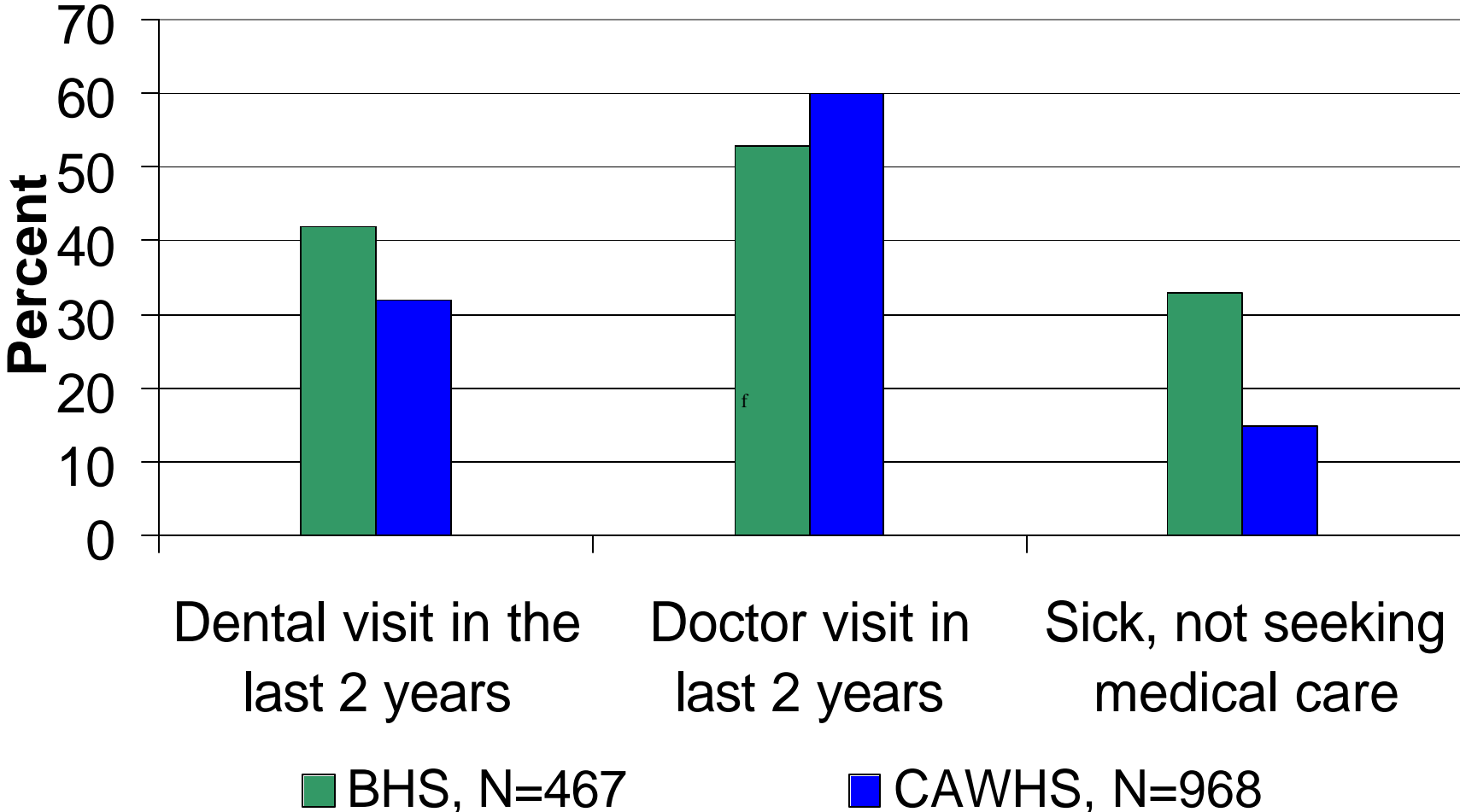
In the BFHS, they pay out of pocket about 40% in US, 80% in Mexico

This leads to high levels of medical debt-- separate survey we found one third of the residents of farmworker towns reported some medical debt and about 12% reported more than \$250.

## Method Of Payment for Health Services Used by Farmworkers (BHS, N=467)



# Doctor and Dental Visits Among Farmworkers in the Last Two Years



Physical exams show despite youth, high risk for CHRONIC DISEASE.

1/5th had 2 or more risk factors of high cholesterol, HBP or obesity.

Cholesterol, blood pressure and overweight charts show high proportion above desirable range.

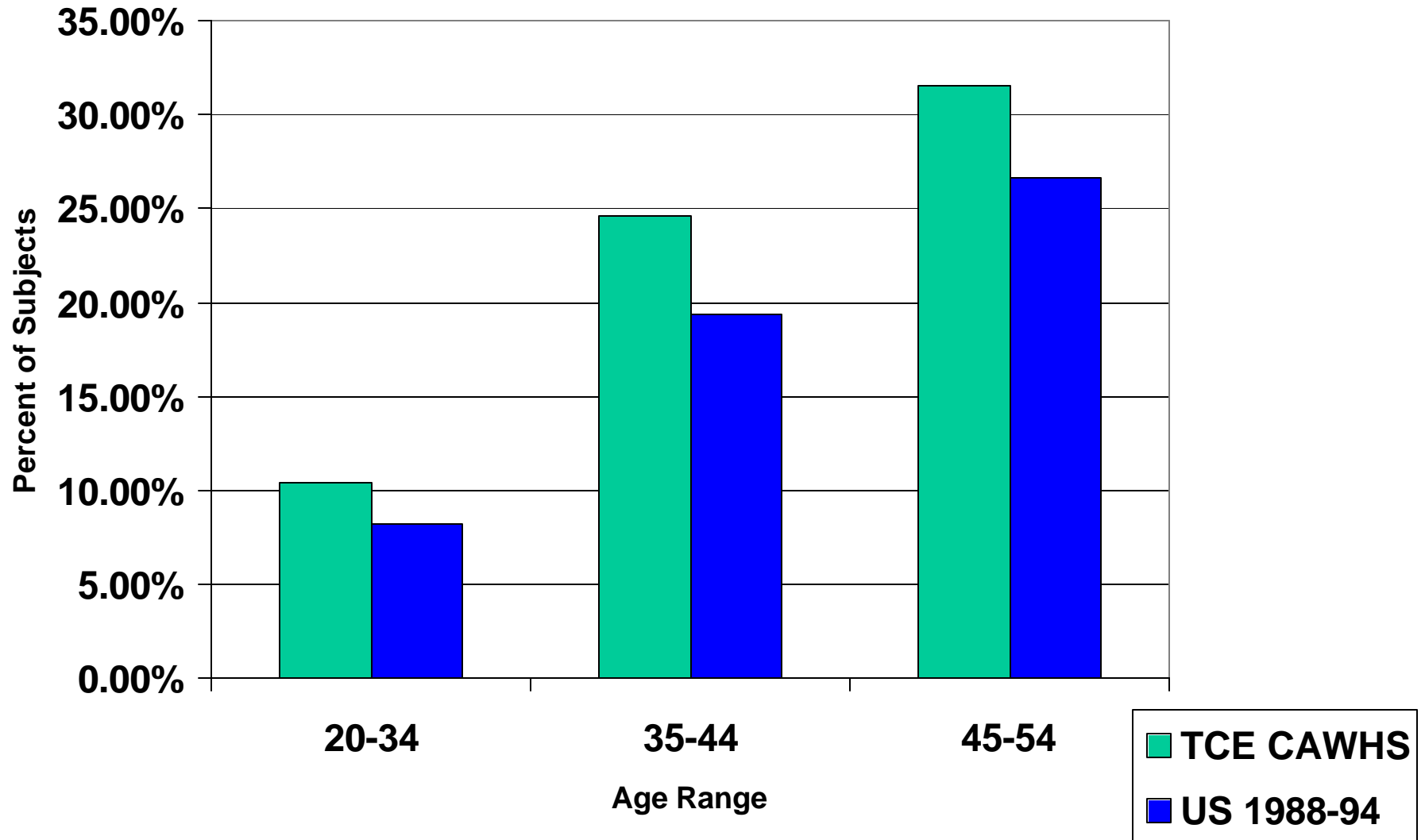
These problems counterintuitive since workers have strenuous job. But, the work is intermittent for most and most of the jobs are not aerobic.

Informants say they are tired; have little energy to exercise aerobically

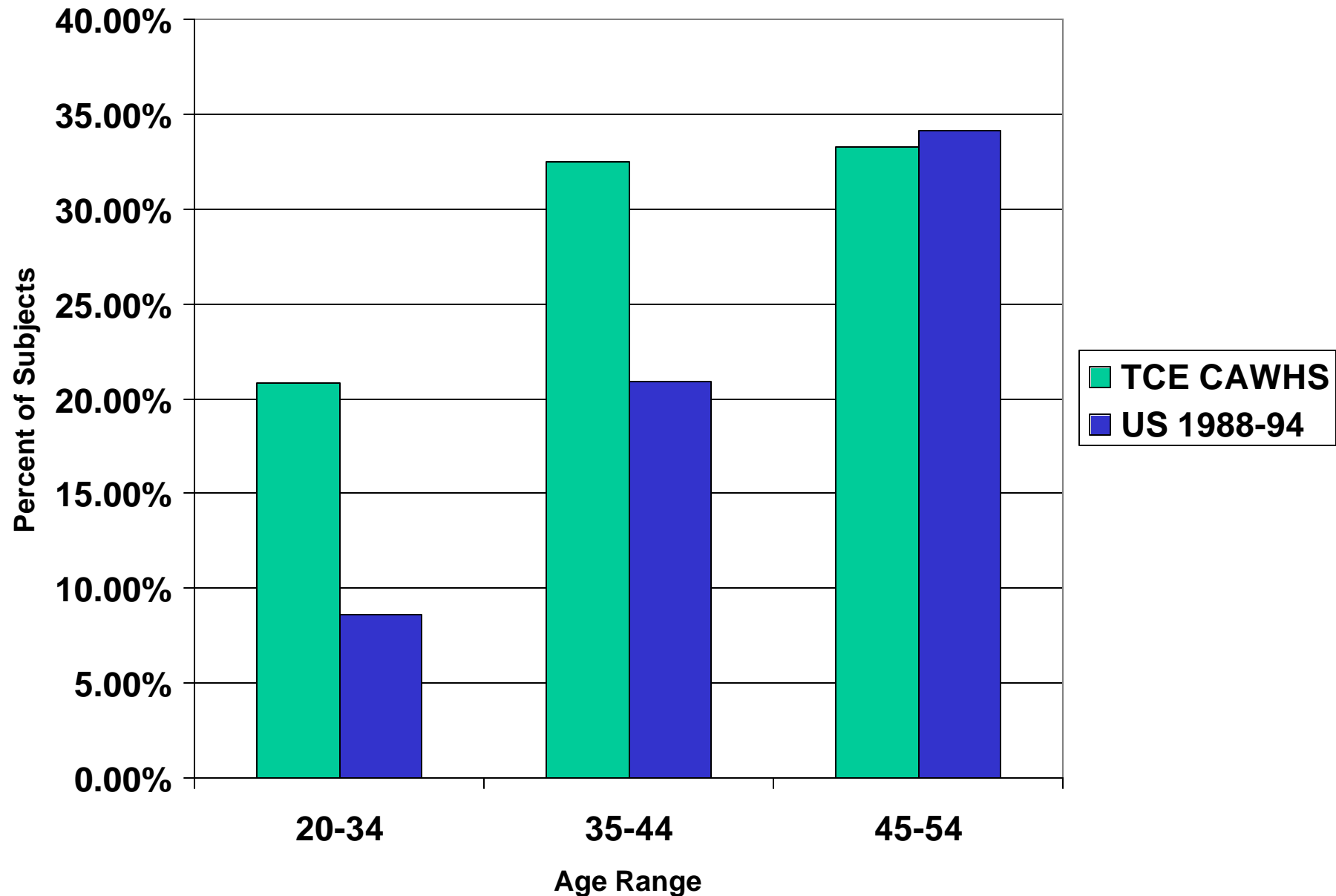
Chronic diseases problem confirmed by BFHS, which includes an older group (average 43); ¼ of current and ex-farmworkers reported having a chronic disease.

BFHS show many of the workers return to Mexico in their old age—where there is no MediCare or other service

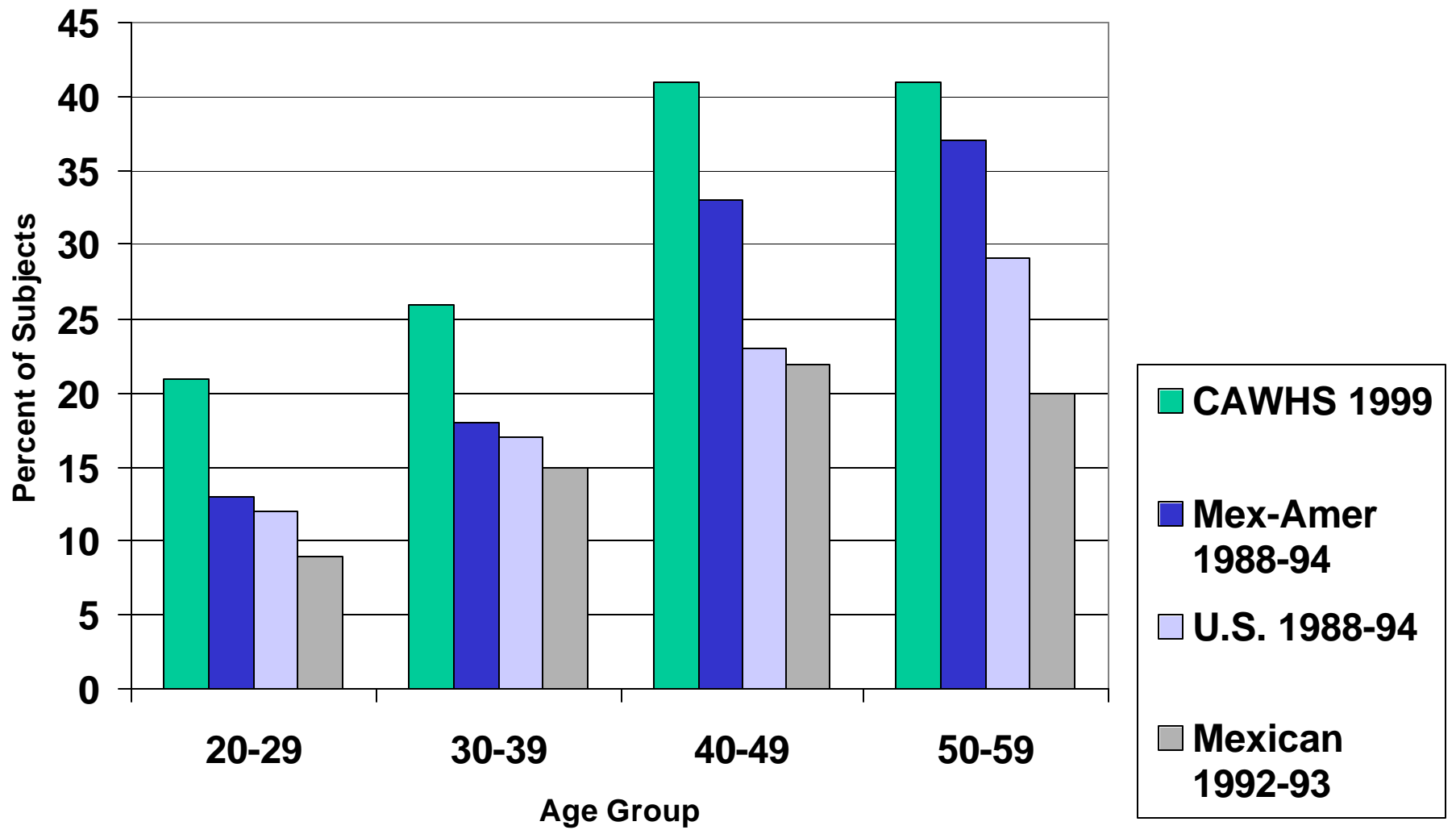
# High Serum Cholesterol, Male Subjects, CAWHS, 1999, N=353



# High Blood Pressure, Male Subjects, CAWHS, 1999, N=353



# Obesity (BMI 30.0 or Greater), Male Subjects, CAWHS, 1999, N=397



## **Work-related Problems:**

Conditions worse today--wages peaked in late 1970s; grower-sponsored housing has declined

Increased government monitoring of issues such as field sanitation and pesticide exposure, but farmworker respondents indicate that improvements are insufficient.

Pesticides, herbicides, dust, and plant allergies are reported as major concerns for farmworkers even though enforcement of pesticide regulations may have increased in recent years.

“They [pesticides] do worry the worker, especially the sulfur. If it gets into your eyes, your eyes just water for like ten minutes and you can’t stop. You have to keep on working. If you get behind, then she [the mayordoma] gets on your back.”

Grapes, users of high level of substance, have big impacts on workers according to the BFHS. (see Symptoms)

## Symptoms Among Grape and Non-grape Workers, (BFHS)

<b>Symptom</b>	<b>Percent of Grape Workers N=75</b>	<b>Percent of Non-grape Workers N=389</b>
Rash	27	9
Itchy eyes	38	13
Headache	18	9

# Mental Stress

Most serious job-related health problem is probably mental stress but data not quantified

Informants complain about poor treatment by the foremen and the isolation from family

Data about mistreatment and isolation are best be gathered using the ethnographic approach we took

Newcomers from immature networks of settlers, are particularly exposed to these problems.

Isolation is particularly associated with poor Spanish speaking skills (indigenous) and with intense INS activity (population terrified)

The CREW LEADER has control over work and often off-work life-  
-mistreatment is widespread

Informants report many crew leaders do not live up to their verbal agreements about pay— foremen under-report hours, undercount piecework, or simply pay with a phony checking account

Overcharge for rides, drinks, equipment and food; many require accepting rides to get job

Informants report that crew bosses arbitrarily dismiss sick workers.

They manipulate people due to undocumented status and discriminate against older workers, women, and the indigenous.

Informants blame these activities for mental disorders and substance abuse

## **Cultural Clash:**

Underlying health difficulties is difficult adjustment process.

Majority grow up in villages or small towns in Mexico.

The health system in their home areas is quite different from the one north of the border

Education received is six years in a small overcrowded rural school; few learn English

They live in U.S. communities where there is only a very partial assimilation into U.S. institutions even for those immigrants who stay for the majority of their lives here.

## Least adapted

Farmworkers represent a subset of the least adapted of the immigrants to US institutions.

Due to the seasonality of employment, the proportion that go back and forth from Mexico on a yearly or at least regular basis is quite high.

Due to the low wages and harsh working conditions, farmworkers with better education or adaptive abilities tend to leave farm work for more stable occupations.

Farmworkers as a group are the most tied to the patterns of the home country and the least adapted among immigrants in the United States to the U.S. style of service delivery

# **Model Of Medicine Used By The Mexican Poor**

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“‘Licenciado’ Physicians/pharmacists dispense care

Incentive for these doctors/pharmacists to sell medicines

Incentive not to educate about alternatives to medicines

Quick service, no waits

Quick treatment, often involving pills or injections

New or no tests, on-the-spot diagnosis

No history kept, no follow up

Good bedside manner

Doctors/pharmacists culturally/linguistically similar to patients

We interviewed 13 practitioners in rural Zacatecas, who told us that in four out of five diagnoses that they do not prescribe any tests.

They said they kept little or no medical history, & no follow up expected.

The doctors, often from the region where they work, have excellent rapport with their co-townsmen.

The workers describe many of these doctors as excellent diagnosticians. They also believe that the Mexican doctors are better at curing their ailments than American doctors.

# Angry at U.S system

Informants were often angry at the U.S. doctors because of the long waits, paperwork, tests and the repeated visits without strong treatment.

Many report they feel cheated by greedy doctors who don't give them care so that they can charge more.

Although they pay more out of pocket in Mexico, workers report that they prefer Mexican medicine (see Preference).

Even for those that have spent three quarters of adulthood in US, a third prefer Mexican Medicine.

## Preference for Healthcare by Work Years in the U.S.

<b>Proportion of Adult Life Spent in the United States</b>				
	<b>Less than 25%</b>	<b>25% to less than 50%</b>	<b>50% to less than 75%</b>	<b>75%+</b>
	(N=72)	(N=121)	(N=119)	(N=98)
<b>Mexico</b>	84%	67%	48%	36%
<b>U.S.</b>	16%	33%	52%	64%

This style clash leads to a series of outcomes

They import medicines from Mexico, including sedatives and anti-depressants.

Many buy underground medicines, including antibiotics, in flea markets or stores. Self-medication is widespread including injections given by unlicensed people.

Many report going to Mexico or using underground unlicensed Mexican doctors and even more use a series of folk healers

Many of these underground techniques are popular in the farmworker community where they are often viewed as effective.

Many suffer from syndromes such as nervios, empacho, susto or mollera caída; they can't get relief for these ailments since the US medical doctors scoff at their suffering.

Our studies show that whatever the skill of US medicine, the outreach to the population is the challenge

The cultural, economic and political barriers due to habits unsuitable for the US put them beyond reach

But, the farmworker communities have extensive and effective communication mechanisms within themselves.

It is best to conceive of these information networks in a binational context since so many of the people go back and forth across the border and seek services in both societies.

In many cases these natural formations can be used to facilitate dialogue with these communities.

The intermediaries can help navigate across the economic, political & cultural barriers preventing positive change in these communities.

But, services cannot be viewed as a top-down delivery from the outside if they are to be effective.

For all the issues raised by our studies including the obstacles to access, the epidemic of chronic illness, and the work-related negative outcomes there is an ever present cultural barrier that underlies them all.

We have chosen to have a working class to tend and harvest our food and fiber that has very different experiences and that doesn't easily adapt.

With this choice of a working class comes a responsibility to attempt to cross this barrier

By not customizing our system for this group, we are spending money that in many ways just irritates the clients; An approach focused on the cultural clash is needed to make a dent in the problem.

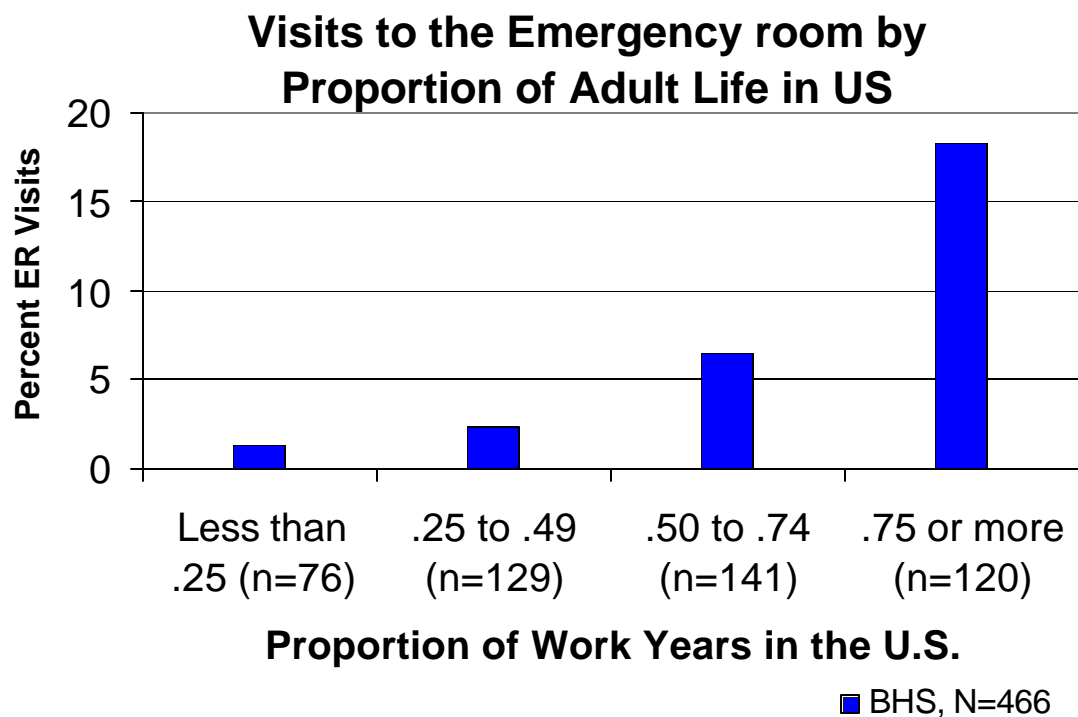
# Covered Groups

Lack of insurance or eligibility for coverage for public programs is much less a factor for certain subgroups

Especially for the children born here and undocumented children and for pregnant women and women under forty seeking help with breast cancer

Ethnographic work in the AWHHS, demonstrates this eligibility flexibility even for the undocumented, but, we don't know how many of those eligible actually use these services since our data on this topic is anecdotal. (e.g. Yang)

# The Rate of emergency use by proportion of adult life spent in the United States



## Length of Pain Experience

<b>Part of Body</b>	<b>Average Length of Pain (Years)</b>	<b>Count</b>
Back, neck	7.5	149
Leg, foot, knee	7.4	93
Arm, hand	6.4	85
Shoulder	7.4	58
Other	7.9	12
Total	7.2	397