Nevada State Health Division

Nevada Migrant Worker Issues in Brief

October 2012

Submitted to the Nevada State Health Division by
Strategic Progress, LLC

Executive Summary

Not much has changed, or so it seems, as we began to research the health and wellness and overall social and emotional welfare of Nevada's migrant worker populations today. Could it be, that hidden in plain sight, many of the problems that plagued this population decades ago still exist? And if so, how can we impact them now?

Our research illustrates that the overall quality of health, wellness, social and emotional welfare of Nevada's migrant farmers hasn't changed over the past decades. Nevertheless, the conditions and civil rights for all the Americans have improved over this time period. Our research focused on interviews with several subjects within this population. These interviews revealed the problems this subset faces with living conditions, lack of safe housing, transportation, chronic health conditions, prevention services and basic healthcare. Also during our interviews it was discovered that half of this population was on work visas and the other 40-50% were undocumented workers. Poverty and lack of education among this group supports our interview findings.

Some of our recommendations based on our research, interviews and literature reviews include:

- Outreach workers need to engage the farmworker community members in discussions to better understand their fear and the underlying causes.
- Advocacy organizations need to conduct more in-depth research on fear and how it creates a barrier in obtaining much needed medical attention.
- Funders and policymakers should support a variety of transportation methods such as mobile health care units, clinic vans, and community-wide collaborations. Transportation is the number one barrier identified by migrant workers.
- Agencies can improve access through extended days and hours clinics are open.
- Farm workers need/want more information and education on system navigation, occupational health and legal rights. It is not just about health education, which is a priority among health centers, but system level assistance.
- Funders and policymakers allocate funding to support group and collaborative health education initiatives.
- Farmworker advocates should enhance their approaches to education by partnering with other community agencies that use popular education methods.
- Service delivery organizations need to ensure cultural competency in their services by employing bilingual program officers
- Prevention must be a focus, even though primary care access is a challenge, we must not lose sight of prevention as a priority

As we move forward, it may be worth conducting a more in depth population study, as this issue brief is just the first step in understating the issues. A second Enumeration project conducted in 1999 here in Nevada could provide invaluable information.

Although the migrant worker population is relatively small, it is still an important population to look at in terms of health, housing, social and emotional welfare, family health and women and children's health. The health issues of these workers and their families should not remain a problem hidden in plain sight.

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NEVADA MIGRANT WORKER ISSUES IN BRIEF
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October 9, 2012

Demographic profile-

Baseline Demographics for Region 9 (includes Nevada, California, Arizona and Hawaii)

According to National Agriculture Worker Survey (NAWS) over 78% of the U.S. farm worker population are male, and most of them are relatively young (average age of 34) with seventh or lower grade education. Among these workers, 65% are married and 51% are parents, but only 48% are accompanied by their families on the job site. In addition, only 17% of the workers are indigenous to this area

Most of the workers state that they are from Mexico (72%) followed by the U.S. at 24%. The Pew Hispanic Center states that there are approximately half a million unauthorized workers within the United States agricultural industry. The Center also states that the percentage of unauthorized workers in the country has quintupled since 1989

There are also additional concerns among workers who are here in the United States working on H-2A visas. This visa requires sponsorship from an employer. H-2A visa workers have different outreach and intervention needs since they are more afraid to access healthcare due to fear that their employer will not sponsor them the following farming season. Farm workers who were surveyed about their health issues states that the following issues are the most significant and concerns them the most.

Farm workers who were surveyed about their health issues stated that the following issues were of greatest concern:

- Diabetes 79%
- Dental Health 50%
- Hypertension 42%
- Alcohol and Substance Abuse 25%
- Prenatal Care 23%
- Occupational Health 17%
- Mental Health 16%
- Nutrition Education 11%
- Sexually Transmitted Diseases 11%
- Eye Care 8%
- HIV/AIDS 6%
- Dermatitis 5%
- Other 5%
- Asthma 3%
- Tuberculosis 1%

These self-identified concerns were supported by qualitative data from community forums and focus groups where migrant/community health centers listed immunizations first as the main concern, followed by health supervision of children and oral exams, diabetes and hypertension were the fourth and fifth top diagnoses.

In addition, workers and health professionals list dental health as a common concern among farm workers, as many workers do not have insurance and dental care is expensive. In addition, the Migrant and Seasonal Head Start Program Information Report issued in 2008 showed that less than one quarter (23%) of farm worker children received preventative dental care treatment.

Another issue is pesticide exposure, which causes many farm workers to deal with asthma, allergies, skin conditions and cancer. There are also education issues that stem from the concern that parents are contaminating their homes and exposing their children to pesticides.

Issues unique to women migrant workers-

Within America's workforce, immigrant and migrant working women are a particularly at-risk group. They face barriers related to their immigrant status as well as issues in balancing work, home, and family that strain and stress their bodies and minds. When, compared to native-born women, immigrant women that work in this sector are prone to much higher injury rates.

Sexist treatment and gender discrimination in the workplace can affect a woman's physical and mental health, and sexual harassment can lead to:

- anxiety
- depression
- lower self-esteem
- alienation
- insomnia
- nausea
- headaches

When family and demanding migrant farm work demands collide, the resulting stress can lead to physical health problems such as poor appetite, lack of sleep, increased blood pressure, fatigue, and increased susceptibility to infection. It can also result in mental health problems such as burnout and depression.

In addition, continuity of care for pregnant migrant women workers is a big issue, posing challenges as women move from place to place and lose track of their records, tests or medical care while they move.

As a result, migrant and indigenous women have a more difficult time accessing sexual and reproductive health services, as well as getting an early diagnosis of an illness and appropriate treatment.

Women are more vulnerable to sexual abuse and violence, which places them at higher risk of sexually transmitted diseases, including HIV and others, as well as a wide range of post-traumatic stress disorders that are associated with sexual violence. Their reproductive health needs often go unnoticed and unprotected even in well-organized migrant situations, and the insensitivity of health staff to the needs of women is often more pronounced in migrant contexts than it is in general.

Migrant child labor- In 2000 Human Rights Watch published Fingers to the Bone: United States Failure to Protect Child Farm workers. This critical report documented the health and educational risks faced by child laborers on America's farms. Estimates of the number of children working in agriculture range from 300,000 (The General Accounting Office) to 800,000 (United Farm Workers union) during the time period studied.

Children who work on farms fall under a different set of labor laws than other children, and are allowed to begin work at 12 years old if accompanied by a parent. The minimum employment age for children working in non-agricultural jobs is 14 years old. Child farm laborers can also work longer hours under the law, and children who are 14 or older can work unlimited hours in the fields before or after school hours. Children who work in any other type of occupation are allowed to work only 3 hours per day while school is in session.

In addition, the United States General Accounting office estimates that there are more than 100,000 children and teens who are injured on farms each year. In addition, such child farm workers are exposed to pesticides at the same level as adults, although because they are younger and weigh less their risk may be higher, according to the Environmental Protection Agency. A study by the National Migrant Resources Program found that migrant children have higher rates of chronic disease (10.9% vs. 3% for the general population) and a death rate 1.6 times higher than other children.

Child health issues- It is interesting, that unlike the general population data there aren't any national data on child health in migrant population such as rates of infant mortality, birth defects, adolescent pregnancy and homicides. However, a health profile of migrant's children can be constructed using the data we gathered and with advice from program providers, parents and stakeholders.

As a general rule, migrant children across the world, as well as in the United States, receive inadequate preventive medical care, are exposed to increased occupational illnesses and injury, have an increased rate of infectious diseases and toxic exposures, an increased risk of family violence and mental health problems, and are subject to nutritional and educational deprivation.

Common and well known problems of migrant families include parental poverty, frequent moves, low health expectations, interrupted schooling, overcrowded living conditions, and poor sanitation facilities. Migrants' children are at increased risk for:

- respiratory and ear infections
- bacterial and viral gastroenteritis
- intestinal parasites
- skin infections
- scabies and head lice
- pesticide exposure
- tuberculosis
- poor nutrition
- anemia
- short stature
- undiagnosed congenital anomalies
- undiagnosed delayed development
- intentional and unintentional injuries
- substance use
- teenage pregnancy

Immunizations and dental care are often delayed or absent, and many migrant children have never been screened for chronic disease or vision and hearing impairment.

Barriers to care-

The biggest barriers to care identified by health serving organizations in a survey in 2006 include these five issues:

- Transportation 67%
- Available services knowledge 58%
- Cost of health services 48%
- Lack of insurance 35%
- Lack of comfort with healthcare services/facilities 22%

Cultural differences and lack of trust in health services are also critical issues, which make outreach, education and health intervention services difficult to deliver.

Many farm workers experience fear on many different levels, such as their true health status, immigration, financial, emotional and physical costs associated with treating their condition. For many workers, it is easier to deny their condition, to continue to work and pretend that life is going to go on as usual.

- Only 39 percent of farm workers reported as being covered by unemployment insurance, whereas, 54 percent mentioned that they were not and 8 percent did not know.
- A mere 8 percent of farm workers reported being covered by employer-provided health insurance, a rate that dropped to 5 percent for farm workers who are employed seasonally and not year-round.
- 22 percent of farm workers said they, or someone in their household, had used needs-based services within the last two years:
- 15 percent used Medicaid
- 11 percent used WIC (Women, Infants and Children)
- 8 percent used Food Stamps
- 1 percent used general assistance or TANF (Temporary Assistance for Needy Families).

Factors contributing to the success of outreach and enabling services-

Studies show that the following factors are contributing to the success of farm worker health programs. The data is presented as the percentage of program officials citing the factor as critical:

- Relationships with farm workers 60%
- Staff dedication 47%
- Administrative support 34%
- Staff cultural sensitivity skills 30%
- Many years of experience 26%
- Staff language skills 20%
- Flexibility with farmworker schedules 20%
- Cross-departmental collaboration 18%
- Patient education 15%
- Training opportunities 10%
- Time spent with each farmworker 9%
- High staff retention 8%
- Other 2%

Organizations partnering with health centers across the country-

As we look forward to meeting the needs of migrant workers across the state, we have to address numerous questions regarding capability and funding. This demonstrates the importance in partnering with other service organizations in order to leverage funding and resources to meet the critical goals. The most common organizations that partners with migrant and local health centers include: Head Starts, Health Departments, Migrant/Bilingual Education, WIC, other community organizations, coalitions or collaboratives, local schools, religious organizations, hospitals and government agencies

Questions we attempted to address in this overview of two relevant articles-

Questions: What are the health issues of Migrant workers? What are the Barriers to Health Care? What are the crops/seasons in Nevada? We are providing summaries from a few notable articles and research papers to better inform the readers regarding migrant workers in Nevada. State level data is difficult to ascertain, as the last Migrant Enumeration Project in Nevada took place in 1999. Due to lack of local data we are providing short summaries from two articles to better illustrate the common migrant worker problems. These problems transcend state boundaries and are common to many migrant populations. Without quality data, a snapshot of current Nevada migrant conditions is difficult to assess.

According to United States Department of Labor and National Agriculture Workers Survey the only state with state level data is California, and this is due to its large faming area. As a result of insufficient data, we have chosen to do a literature review. This will provide valuable information about migrant workers and will help the Health Division's mission in providing quality health service.

ARTICLES IN BRIEF

Article: *Health Issues of Migrant and Seasonal Farm workers*
Citation: Hansen E, Donohoe M. Health issues of migrant and seasonal farm workers. J Health Care Poor Underserved. 2003;14(2):153–164.

- **Article Highlights**:
  - Focuses on health issues and barriers, lack of compliance on behalf of the farm owners, low reporting rate and language barriers. This article states that all numbers are estimates as they are not able to "find" the migrant workers. Also, some farms employ more than 11 workers, omitting them from following the regulations outlined by OSHA.
- **Economics:**
  - Outlines the economic impact of Migrant workers. 1990's – brought in $45.5 billion per year.
  - Provided information on typical migrant workers salaries. One half earns less than $7,500 the other half is less than $10,000 a year.
  - 61% of farm workers (individual) and 50% with families are below poverty level.
- **Family Demographics and statistics of Migrant workers:**
  - 80% male
  - 66% younger than 35; median age is 29
  - 52% married; 55% migrate together and work together
  - 45% have children
  - 81% are foreign born
  - 95% from Mexico, 84% predominate language is Spanish
    - **Education**
      - 6th grade - median educational attainment
      - 20% illiterate even in their native language
      - 38% functionally illiterate
      - 27% marginally illiterate – **these are barriers to accessing health care.**
- **Safety Issues:**
  - Inadequate/cramped housing – employers are unable/unwilling to pay for housing that meets standard-meeting labor camps:
    - No laundry facilities – increased exposure to pesticides
    - Poor ventilation
    - Non-existent/inadequate plumbing – leads to infectious diseases
    - Garbage heaps and rodents
    - Some employers do no offer housing so migrants sleep in tents and cars
  - Occupational Hazards:
    - Exposure to extreme weather. Most farm work is completed during the summer months.
    - Stoop labor, working with soil, heavy lifting, loud machinery – leads to musculoskeletal symptoms
    - One of the most hazardous jobs in the US – accounting for 780 deaths in the US in 2000 and 130,000 disabling injuries
    - Underreporting is significant

- **Barriers to access health care –** limited access to healthcare services, different cultural conceptions of health and disease, fear of loss of employment and loss of wages.
- **Health Issues:**
    - Lower life expectancy; 49 years
        - **Infectious Disease:** viral, bacterial, fungal and parasitic infections
            - 6 times more likely to have TB
            - 11 to 59 time higher to have parasitic conditions leading to anemia or malnutrition.
            - Sexually transmitted diseases - HIV -2.6 to 13% among migrant workers compared to the national rate of .04
            - Urinary tract infections
        - **Chemical and Pesticide- related illnesses:**
            - Highest rate of toxic chemical injures
            - EPA estimates that 300,000 farm workers suffer acute pesticide poising each year.
            - Cause by:
                - Direct spraying of workers
                - Wind drifts
                - Contact with pesticide residue on crops
                - Bathing in and drinking contaminated water
            - Impacts on Health:
                - Acute: increased salivation, tearing, blurred vision, nausea, vomiting, abdominal cramps, urinary and fecal incontinence, respiratory issues
                - More severe long-term: hypotension, pulmonary edema, paralysis, convulsions and death.
        - **Dermatitis:**
            - Skin disorders from exposure to chemicals, latex, and allergic plants.
            - Absence of hand-washing facilities.
            - Weather
        - **Respiratory Conditions:**
            - Workers are exposed to hazardous agents – organic and inorganic dusts, gases, herbicides, solvents, fuels, and welding fumes
            - High risk for mucous membrane irritations, allergies, asthma, “farmer’s lung,” chronic bronchitis, pulmonary edema, emphysema, and asphyxiation
        - **Traumatic injuries:**
            - Caused by heavy lifting, prolonged kneeling stooping etc.
        - **Reproductive Health:**
            - Prolonged standing, bending, overexertion, dehydration, poor nutrition, and pesticide/chemical expose increases miscarriages, premature delivery, birth defects such as Down syndrome.
            - Most woman have no prenatal care – low wages, lack of healthcare, young maternal age has caused the infant mortality rate to be twice the national average.

- **Child Health:**
  - Exposure at a young age to pesticides
  - Children as young as 12 years of age are legally allowed to participate in agricultural labor.
- **Oral Health:**
  - 150% to 300% more decayed teeth than their peers
  - Impacts migrant children
  - Lack of knowledge regarding dental care
- **Cancer:**
  - Exposed to carcinogens
  - Few studies on migrant farm workers
- **Social/Mental Health:**
  - Sources of stress:
    - Poverty, isolation, time pressures, poor housing conditions, separation from family, health and safety concerns, and lock of recreation all have an impact on mental health.
    - Causes relationship problems, substance abuse, domestic violence, and psychiatric illnesses

- **Barriers to Health Care:**
  - Lack of transportation, insurance, lack of sick leave, which causes lost wages or job loss and language barriers. Additionally, clinic hours do not meet the needs of farm workers because of their extensive hours.
  - Illiteracy – further limit their access to health care.
  - Migrant workers have increase hospitalizations and mortality rates for common conditions such as pneumonia.
  - Lack of follow-up for illnesses such as HIV, TB and diabetes.
  - Migrant workers are eligible for assistance programs however only 15-20 percent access them. This may have a direct correlation with the number of federally authorized clinic sites (400 of them) and the fact that they only reach 15-20 percent of the migrant population annually.
  - They also do not seek assistance through programs due to fear of immigration penalties and lack of knowledge. Further employers do not report wages of workers and they are often unable to prove claims.

- **Suggestions to improve the health of MSFW (Migrant Seasonal Farm Workers):**
  - Create a stronger health infrastructure
  - Education
  - Increase preventative services
  - Employ more community outreach workers
  - Bilingual/bicultural healthcare workers

Article: Brea*king Down the Barriers* (this article was cited extensively in this brief)
Citation: Health Outreach Partners. (2010). *Breaking down the barriers: A national needs assessment on farmworker health outreach* (Report). Retrieved from http://outreach-partners.org/docs/FANpercent20Reportpercent20Edn.4.pdf

- **Article Highlights**: This document produced by Health Outreach Partners in 2010 highlights the needs, barriers, and recommendations reach migrant farm workers in the US.
- **Data Collection:**
  - **They used five methods:**
    - Three community forums, including outreach staff sample of 82 attending the migrant stream forums.
    - Three focus group discussions – included a sample of 34 migrant worker parents and Seasonal Head Start Parent Policy Councils.
    - On-line survey – migrant health grantees – 108 out of 150 responded.
    - Telephone survey to a random sample of 24 migrant health administrators.
    - Review of data from existing research studied.
- **Barriers:**
  - Top farmworker barriers to healthcare (identified by migrant healthcare professionals):
    - Transportation – 67%
    - Lack of knowledge of available services – 58%
    - Cost of services – 48%
    - Lack of insurance – 38%
    - Lack of comfort with healthcare services and/or facilities – 22%
    - Migrant parents and farm workers both report confusion when trying to navigate the healthcare system. This is a major barrier in addition, to their lack of knowledge on how to access insurance and other healthcare programs.
    - Additionally, most migrant workers are not eligible for insurance due to their legal status.
    - Many migrant workers live in rural areas, with little or no access to transportation.
    - Fear is a large barrier. Many migrant workers live in fear due to lack of documentation. They fear being discriminated due to their immigration status.
    - They fear their employers. Many of them report that employers threaten them with lost wages, termination of employment and deportation if they have health issues or want to access healthcare.

- **Current Outreach/Data:**
  - Most frequently performed outreach activities are:
    - Health Education – 50%
    - Basic Health screenings - 38%
    - Health Fairs and Community events – 37%
    - Interpretation – 33%
    - Farm workers are asking for more education/information in the following areas
      - Pesticides,
      - Legal services
      - Managing chronic diseases
  - Navigation of the healthcare system.
    - Outreach barriers:
    - Lack of transportation and lack of staff
    - Outreach frequently must occur at celebrations, inside the clinic and community agencies.
  - Other Data:
    - Funding issues:
      - Grants are sparse and sporadic. Most grants have short funding periods, forcing health care centers to continuously seek new funding sources.
      - 2007 – 1.3 million spend on enabling services.
      - $55 per user.
    - Staff Data:
      - For every 15 staff on average there is only1outreach staff per center.
      - Three top characteristics contributing to success are relationships with the farm worker community, dedication of staff and administrative support.
      - Interpretation – It's an invaluable resource, migrant outreach workers reported it could interfere with their ability to fulfill other essential community-based services within the community.
      - Lack of staff is a key challenge.
      - There is an overwhelming desire amongst the workers and farm workers to strengthen clinic staff's understandings of their culture.

- Needs and Community Collaboration:
    - 81% of Migrant worker health professionals (4 out of 5) reported working with Migrant and Health Start agencies.
    - Migrant health professionals reported that the assistance with Medicaid or other applications for services is the greatest concerns among farmer workers. (66%; n=100)
    - According to the farm workers education on where and how to access social services is a need of theirs.

Recommendations:

- Fear:
    - Fear was one of the biggest reasons migrant workers do not obtain much needed services.
    - Outreach workers need to engage the farmworker community members in discussions to better understand their fear and the underlying causes.
    - Advocacy organizations need to obtain more research on fear and how that creates a barrier. Resources need to be developed around how fear impacts the farm workers.
- Transportation:
    - Funders and policymakers should support a variety of transportation methods such as mobile health care units, clinic vans, and community-wide collaborations. Again, transportation is the number one barrier identified by migrant workers.
    - Agencies can share existing transportation resources.
- Education:
    - It is not just about health education which is a top priority among health centers; farm workers need/want more information and education on system navigation, occupational health and legal rights.
    - Funders and policymakers allocate funding to support group and collaborative health education initiatives.
    - Farm worker advocates should enhance their approach to educate this population by partnering with other community agencies that have successful education models.

Article: *State Facts Sheet: Nevada*
Citation: State Fact Sheet: Nevada; Prepared by Economic Research Services, USDA, Washington, DC; May 2, 2012.

- **Income:**
  - 2010 Rural Per-Capita Income (2009 dollars) $36,469
  - 2010 Rural earnings per job (2009 dollars) $42, 489
  - Poverty Rate 2010 based on estimates in the rural area 11.8
- **Farm Characteristics (2007):**
  - Total land area (acres) 70,252,997
  - Farmland (acres) 5,865,392
  - Cropland (acres) 753,718
  - Cropland in farmlands 12.9%
  - Cropland in pasture 24.6%
  - Copland irrigated 66.7%
  - Harvested Cropland (acres) 504,311
- **Average Farm Size:**
  - In acres – 1,873
  - Farms by size:
    - 1 to 99 acres – 58.7%
    - 100 to 499 acres – 20.1%
    - 500 to 999 acres 6.9%
    - 1000 to 1,999 acres – 4.8%
    - 2000 or more acres – 9.5%
- **Farms by Sales:**
  - Less than $9,999 – 57%
  - $10,000 to $49,999 – 17.6%
  - $50,000 to $99,999 – 5.7%
  - $100,000 to $499,999 – 13.2 %
  - More than $500,000 – 6.5%
- **Tenure of farmers:**
  - Full Farm Owners (farms) – 2,490
  - % of Full Farm Owners – 79.5
- **Farm Organization:**
  - Individual. Family, sole proprietorship (farms) – 2,543
  - % of individual, family, sole proprietorship – 81.2
- **Net farm income:** $137,760 average among the 3,100 farms in Nevada

- **Top 5 Commodities and Exports:**

Top 5 agriculture Commodities in 2010	Farm receipts 1,000 dollars	Farm receipts percent of state	Farm receipts percent of U.S.
Cattle and Calves	217,776	39.2	.4
Dairy Products	103,766	18.7	.3
Hay	99,160	17.9	1.8
Onions	67,340	12.1	5.6
Potatoes	14,286	2.6	.5

- **Top 5 counties in agricultural sales, 2007**

Counties	Total receipts percent of state	Total receipts 1,000 dollars
Lyon County	17.8	91,108
Humboldt County	14.5	74,355
Churchill County	13.0	66,921
Nye County	11.3	58,238
Elko County	10.4	53,599

In a brief interview with Charles Moses of the Nevada Department of Agriculture, based on his research from 2009, there are approximately 5,000 migrant workers in Nevada. The vast majority of migrant workers are employed in Yerington and Smith Valley in Lyon County. Another region where some migrant workers are employed is in the Winnemucca-Orovada Region of Humboldt County. Major crops include onion, garlic, potatoes, alfalfa seed, and alfalfa. Other crops include timothy, mint, and small grains (wheat and barley). Garlic and winter wheat are planted in the fall. Once planted, alfalfa is a perennial crop and doesn't have to be replanted each season, and is harvested 2 or 3 times a season.

Potatoes: $15,000,000 annually
Mint: $2,850,000 annually
Small Grains: $12,000,000
Alfalfa and Alfalfa Seed: $150,000,000
All Other Hay: $200,000,000

Although further research through USDA Agriculture Statistics may lend more recent data, this information helps to understand the local farm worker locations for improved access, understanding of health and work related needs.

KEY INFORMANT INTERVIEWS

LISA NIERI INTERVIEW

I interviewed Lisa Nieri, Migrant Worker Health Program Manager for the Arizona Association of Community Health Centers about the health and wellness of Nevada migrant workers as well as issues and trends that she saw regionally with this population.

Ms. Nieri stated that most migrant workers in the southwest work during June-September and harvest potatoes, garlic and onions. Peggy McKai, an agriculturalist with the Nevada Department of Agriculture, reported wheat is harvested in Nevada for hay and many migrant workers also work on this, and some stay longer to work on alfalfa crops. She reported there is no data written on this, as data about migrant workers is lacking in the state. John Packam, Director of Health Policy Research, University of Nevada School of Medicine, confirmed this and stated that we did not have a good deal of data around this population at the state or local level.

Lisa Nieri is a specialist in migrant worker health and wellness who is affiliated with Arizona Primary Care Association (PCA). Ms. Nieri was one of eight regional migrant health coordinators. She reports that there is a PCA in every state in addition to a special population contact person. They are moving away from having regional coordinators to state level coordinators, this would help gather and enhance reporting efficiently.

The National Center for Farmworker Health is a HRSA grantee that is part of the farmworker health system. The National Center for Farmworker Health is a private non-profit organization which provides information and products to migrant health centers as well as organizations, universities, researchers and others involved in farm worker health.

Ms. Nieri stated that there aren't any solid data related to the Nevada migrant worker population. The last in depth study was completed years ago with Nevada Migrant and Seasonal Farm Worker Enumeration Project. Contacting and conducting a survey in this population is very difficult due to the nature of their job and the location. Our best estimates are outdated, and also there is the problem of this population being in a minimum threshold. Nevada is just too small to quantify in detail.

Nevada does not have any designated migrant health centers, so that none of our health centers are funded specifically to serve this population. This might be due to lack of funding or lack of interest in submitting grant application.

The National Center for Farmworker Health came up with threshold estimates using the crops and man hours to determine the following numbers:

- Horticulture- 2,013 farm workers. If you include dependents which would be eligible to be served at migrant health centers, close to 5,000.
- Livestock workers estimated at 4,800. Eligible to be counted as migrant seasonal farm workers.

In terms of a demographic profile, generally speaking there are between 2-3 million farm workers in the United States and 70% are from Mexico. The majority of farm workers are men, but the number of women doing seasonal farm work is growing. Currently the data says that about 67% male and 33% female, reported by people working directly with the population. Sexual assault is an issue, as well as domestic violence, which is often not treated or attended to. These types of specialized programs are not available, and often are not prioritized as access to health care in general is a large problem for migrant workers.

Access to healthcare is difficult for this population in general, so specialized healthcare is even more difficult to obtain. The community health centers, which start on sliding fee scales, make it possible to be served regardless of insurance status, ability to pay or documented citizen status. These can be valuable resources in communities.

When we demonstrate trends across the region, one thing we have seen is the movement of workers across statelines due to immigration issues and work requirements. In addition pesticide exposure, repetitive motion injuries, asthma, cardiovascular disease, depression, muscle strain and lack of immunizations are commonly seen across the region.

Ms. Nieri stated that she wished we had a migrant worker center in NV, and mentioned that the data we had gathered was the most accurate at this time.

MIGRANT STAKEHOLDER INTERVIEW

As part of the project the author interviewed a Catholic priest with a long history of working with migrant workers in Nevada. He ministered to a large population of migrant farm workers. He had a lot to say about the conditions of migrant workers in terms of their housing, health, social welfare and wellness.

According to this priest, a big problem for migrant workers concerns the houses they live in, where there may be as many as 16 men living in the home when there should be only 6. When the health department comes to check they prepare it for the visit then they put the houses right back to the way they were. There is one bathroom for 14-16 men, which leads to health problems and issues. They get back from work and have to shower and share that small space, presenting a number of issues.

There are men who are married in Mexico, but they come by themselves while their wives are in Mexico. They have the visa. Some come for 6 to 8 weeks, while others will stay for the packing of the food.

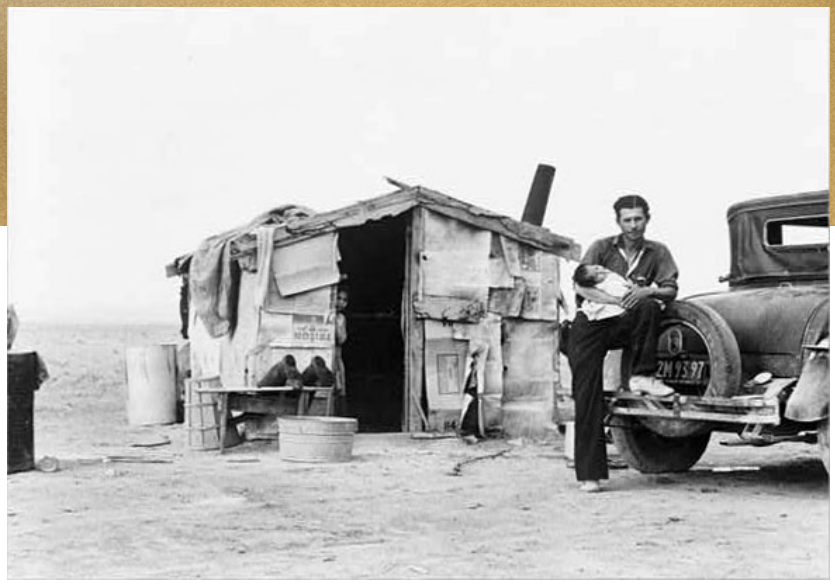
He also stated that workers have many rash issues, and skin conditions due to the chemicals they use doing their jobs. They are not allowed to go to the doctor; or rather they are told that if they go they will have to pay the owners back. So whatever they feel, or whatever they have, they just suffer. The migrant workers know they can get their health issues fixed in Mexico for 100 dollars or so, so they don't go to the doctor here. If they get sick they get sent back to Mexico, so they don't even want to say they are sick.

Having a small clinic or someone to come in and do testing and other things would be a big help. They got a grant in Yerington from the state to do sexually transmitted disease testing a while back, but it was not as successful as it could be and the Catholic priest stated that he thinks they did not promote it enough. Also, the program was run out of the church and the employers know they were doing things for the workers, so they told them to stop going. The workers are told if they go even to get free services they could lose their jobs, so the issue of paying for services is not the biggest, or only issue. Owners do not want workers organizing, getting information or in any other way empowering themselves.

This stakeholder stated that if we could just get the message across to the owners that we are not trying to go after them, but to serve the population, we would have more success. We would need to let them know that we are not going to destroy the company, but are trying to help the workers who need help so they will be healthier and more productive.

Transportation can also be a huge barrier, as many of the farms do not offer any van or other transportation anymore. In the past they used to have cars and minivans bringing them to the living place into town to shop, and eat, but then residents of the town complained that there were too many migrant workers there, so they stopped the transportation. Men have to walk 3-4 miles just to get to town, after they work so hard in the fields all day. They are also told not to congregate, or work in groups, but that they must walk individually. It's more like a concentration camp then American labor, he said, hidden in plain sight in America.

HIDDEN IN PLAIN SIGHT IN NEVADA



Based on our research, interviews and literature review our recommendations for practice changes moving forward include:

- Outreach workers need to engage the farm worker community members in discussions to better understand their fear and the underlying causes.
- Advocacy organizations need to conduct more in-depth research on fear and how it creates a barrier in obtaining much needed medical attention.
- Funders and policymakers should support a variety of transportation methods such as mobile healthcare units, clinic vans, and community-wide collaborations. Again, transportation is the number one barrier identified by migrant workers.
- Agencies can improve access through extended days and hours clinics are open.
- Agencies can share existing transportation resources.
- Farm workers need/want more information and education on system navigation, occupational health and legal rights. It is not just about health education, which is a priority among health center, but system level assistance.
- Funders and policymakers allocate funding to support group and collaborative health education initiatives.
- Farm worker advocates should enhance their approaches to education by partnering with other community agencies that use popular education methods.
- Service delivery organizations need to ensure cultural competency in their services by employing bilingual program officers
- Prevention must be a focus, even though primary care access is a challenge, we must not lose sight of prevention as a priority

As we move forward, it may be worth conducting a more in depth population study, much like the Enumeration project conducted in 1999 here in Nevada.

Although the migrant worker population is relatively small, it is still an important population to look at in terms of health, housing, social and emotional welfare, family health and women and children's health. The health issues of these workers and their families should not remain a problem hidden in plain sight.

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