MIGRANT AND SEASONAL FARMWORKERS

HEALTH CARE ACCESS AND HIV/AIDS IN THIS POPULATION

Statewide AIDS Services Delivery Consortium Advisory Group
New York State Department of Health
AIDS Institute

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Migrant and Seasonal Farmworkers

OVERVIEW

Most of the produce we eat in the United States is planted, nurtured and harvested by migrant and seasonal farmworkers (MSFWs). Migrant farmworkers move from one state to another or sometimes within the same state to do agricultural work. Seasonal farmworkers live in one place year-round, doing agricultural work part of the year and other work (e.g., construction or factory shift work) during the off-season. "Farmworkers in the United States" (Embrey, n.d.) describes what life is like for MSFWs:

> "S*tooping over to plant or pick vegetables on the ground, sliding along on one's knees, or climbing ladders to pick fruit from the high branches of a tree – all involve hard physical labor. When picking, the workers must lift and carry the heavy container…to a central holding container or truck. The work must be done despite the extremes of heat and cold. The perishable nature of the crop means the hours can be long – from sun up to sunset. For some, there is no day off until the crop has been harvested…*
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> *"They lead a life isolated from the rest of American society. Living in labor camps and housing hidden on back roads or in shared rooms in villages and cities, they are often invisible even to residents of the towns where they come to work…*
>
> *"Farmworkers cannot earn money when they are sick, when it rains, while waiting for crops to ripen, when the crop is small and their work is limited, or when they are traveling to their next job."*

The Kaiser Commission on Medicaid and the Uninsured issued a report in April 2005 entitled *Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care* (Rosenbaum and Shin, 2005), which provides a snapshot of this population. The Kaiser Commission Report relies heavily on information in the 2000 National Agricultural Worker Survey (NAWS), a periodic national survey of farmworkers conducted by the United States Department of Labor (F), and the Uniform Data Systems (UDS) maintained on federally-funded health centers by the United States Department of Health and Human Services, Health Resources and Services Administration. It is important to acknowledge that despite these data sources, addressing the needs of this population is particularly challenging because there is limited data on MSFWs within a particular state at any given time as a result of their high degree of mobility.

These data sources provide a profile of MSFWs nationally:

- There are an estimated three million farmworkers in the United States.

- Only 6% report being born in the United States. The overwhelming majority are from Mexico; some farmworkers are from other Central and South American countries, the Caribbean Islands, the Philippines, Southeast Asia, and Sub-Saharan Africa.

- About 90% say they read and speak little or no English.

- They are predominantly male (88%), over half are married (52%), and about 4 in 10 have children (44%).

- Their median income in 2000 was $6,250, compared to $42,000 for U.S. workers overall, even though MSFWs report working five to six days a week.

MSFWs struggle to survive as part of their daily lives. This is illustrated by the following points from "Facts About Farmworkers in the U.S. and New York State," based on information compiled by the National Center for Farmworker Health, Inc. and the Cornell Migrant Program:

- Farmworker housing is often substandard or non-existent. The housing that does exist is often very overcrowded, lacks adequate sanitation and working appliances, and contains severe structural defects. As a result, many farmworkers are unable to store food safely, prepare a warm meal, or even shower after a long day of working the fields.

- It is estimated that about half of foreign-born farmworkers are here without valid immigration documents. As a result, they fear loss of their jobs and deportation – a fear that has heightened in recent years as changes in immigration policies are debated and border enforcement has increased.

- Many farmworkers report experiencing prejudice and hostility in the communities in which they live and work.

Regarding health status and use of health care, the Kaiser Commission Report (Rosenbaum and Shin, 2005) indicates that MSFWs and their family members face health challenges related to the nature of their work, their extreme poverty and mobility, and living and working arrangements that impede access to health coverage and care. The Report concludes that "the low utilization patterns among farmworkers are not a reflection of limited health care needs. Migrant and seasonal farmworkers are often in poor health and they are at elevated risk for an enormous range of injuries and illnesses due to the nature of their jobs." MSFWs face numerous barriers to care which include,

among others: cost, language barriers, lack of transportation and fear of job loss and deportation. The Report indicates further that the great majority of migrant and seasonal farmworkers has no health insurance and has limited access to health care:

- 85% of MSFWs were uninsured in 2000, compared to 37% of low income adults nationally.
- 90% of children in MSFW families were uninsured compared to 22% of low income children nationally.
- In 2000, only 20% of MSFWs reported using any health care services in the preceding two years.
- One study found that only 42% of women in farmworker families reported seeking early prenatal care compared to 76% nationally.

Data from studies of MSFWs relating to HIV/AIDS indicate a high degree of risk and inadequate access to testing and care, as summarized in "HIV/AIDS Farmworker Fact Sheet" (National Center for Farmworker Health, Inc., n.d.) and other reference materials noted at the end of this report:

- While precise data on farmworkers infected with HIV is not available, some researchers have identified rates of infection that range from 2.6% to 13% of farmworkers.
- Studies indicate low knowledge levels of basic facts regarding HIV/AIDS among MSFWs, which may lead to elevated risk of transmission.
- Other studies indicate high rates of behaviors that could result in transmission – multiple sex partners, no or inconsistent condom use, and needle sharing.
- Surveys of farmworkers show that only about one-third report ever being tested for HIV which means that infected farmworkers are likely to learn their HIV diagnosis at later stages of disease progression.
- It is extremely challenging to ensure HIV infected farmworkers receive comprehensive, state-of-the-art HIV care and medications on a continuous basis due to the barriers inherent in their lifestyle, as well as their frequent mobility.

This report draws upon focus groups, a survey, and interviews of MSFWs and service providers conducted in New York State, as well as the resource materials in the Reference listing at the end of this report. This information is summarized to describe MSFWs and the above topics in greater detail, emphasizing issues relating to HIV/AIDS,

barriers to accessing health care and related services, and common elements of successful MSFW programs.

In summary, limited available data indicate that HIV/AIDS is escalating among migrant and seasonal farmworkers and could have a devastating impact among this population and their families unless immediate steps are taken. R**ecommendations are offered at the end of this report with the goal of improving health outcomes among MSFWs, preventing HIV transmission, and providing continuous, comprehensive care and support for MSFWs who are HIV-infected. Recommendations are made in the following categories:**

- **Establishing Trust, Cultural Competence and Addressing HIV Stigma and Discrimination**
- **HIV Prevention, Testing and Linkage to Care**
- **Access to Comprehensive Care, Case Management and Enabling Services**
- **Treatment Adherence**
- **Quality of Care and Services**
- **Coordinating Care Across Geographic Boundaries**
- **Data, Research and Planning**
- Policy Issues Relating to Improving Overall Health Status of MSFWs

BACKGROUND

The East Coast Migrant Stream

There are three major traveling routes or streams that migrant farmworkers tend to follow: the East Coast Stream, the Mid-Continent Stream, and the West Coast Stream. The East Coast Stream starts in Florida and extends through the Carolinas, the Mid-Atlantic States, Ohio, New York and New England. Migrants following the Mid-Continent Stream branch off through the central states as far north as Michigan, Minnesota, Montana, or Washington. The West Coast Stream begins in California and goes through Oregon and Washington.

Most workers who come to New York travel along the East Coast Stream. About 75% of the farmworkers that live and/or work in New York move along the East Coast Stream. Most farmworkers traveling the East Coast stop to work in Georgia, the Carolinas, Virginia, New Jersey, or New York, depending upon which crops they are skilled in harvesting, when the crops are ready, and what arrangements they have made with the work crew leaders and the growers (U.S. Department of Labor, NAWS 2001-2002, 2005).

The stream begins in the late fall and winter in Florida with the harvesting of vegetables and citrus fruits. Workers then move to Georgia in the spring to harvest peaches and onions. From there they move either northwest to Ohio or Michigan or further northeast to the Carolinas and the Delmarva Peninsula to harvest summer fruits and vegetables. In the late summer and early fall, they reach New York and New England in time to harvest apples and grapes, as well as vegetables such as onions, corn and potatoes. Other MSFWs traveling to New York work on duck and poultry farms (Rosenbaum and Shin, 2005).

What We Know about HIV/AIDS Data and Risk Factors Among Migrant and Seasonal Farmworkers

Accurate and consistent nationwide and statewide HIV epidemiological data on MSFW and HIV/AIDS is practically non-existent. The lack of specific data can be attributed at least in part to their mobility and disenfranchised status.

A recent article, "The Epidemiology of HIV Among Mexican Migrants and Recent Immigrants in California and Mexico," published in the November 2004 supplemental edition of the *Journal of Acquired Immune Deficiency Syndrome*, and co-authored by Dr. George Lemp, head of the University of California AIDS Research Program, indicates: "Until recently, the prevalence of HIV in Mexico and among Mexican migrants in California appeared to be stable and relatively low. Recent studies have raised new concerns, however, that the HIV epidemic may expand more aggressively among this

population in the coming years." The article concludes that "it is imperative that this potential threat be assessed and that intervention programs are developed and put into place to thwart this possible surge in the HIV epidemic." (Sanchez, et al. 2004).

The National Center for Farmworker Health, Inc. (NCFH) conveys in their "HIV/AIDS Farmworker Fact Sheet" that while precise data on farmworkers infected with HIV is hard to determine, some researchers have identified rates of infection that range from 2.6% to as high as 13%. However, based on a review of the literature, these data must be interpreted with caution because of the limitations of available studies. For example, in the *JAIDS* article cited above, the authors indicate that the studies referenced for their article "differed in target study population and specific methodology. Some of the key studies examined Latino populations as a group and did not differentiate the findings for Mexican migrants, recent immigrants, or the Mexican-origin population as a whole. Other studies targeted only one localized subpopulation or sampled persons from an undefined mixture of public venues." These limitations lead the authors to recommend "an urgent need for an ongoing binational surveillance system to assess prevalence and trends in HIV/STD/TB disease and related risk behaviors in the Mexican migrant populations in California and within the originating "sending" states within Mexico."

In terms of risk behaviors relating to HIV transmission, the above published article notes the following concerning studies of Mexicans and Mexican migrants, not necessarily MSFWs:

- A recent sample survey targeting young Latino Men Who Have Sex with Men (MSM), aged 18-29 years, in San Diego, California and Tijuana, Mexico suggests that HIV is substantially affecting MSM on both sides of the border. High-risk venues from each jurisdiction were targeted from May 2000 to Spring 2002. HIV prevalence was 35.2% for Latino MSM in San Diego and 18.9% for a similar population in Tijuana. A significant proportion of MSM in this study reported engaging in risky sexual behaviors with both men and women. The articles notes that while "issues of sampling and statistical power need to be considered when evaluating the results, these high prevalence estimates warrant further study and intervention…." It is important to note that Latino men engaging in sex with another man may not identify as gay or bisexual and therefore not perceive themselves to be at risk.

- "Other studies have found that the injection of illegal drugs is relatively rare among migrant farm workers but that the sharing of needles to inject vitamins and antibiotics is far more common." Injections are popular because they work fast, and disposable syringes are sometimes shared among family members. Whereas clean needles are available over the counter in Mexico, migrants in the United States are more likely to share syringes because they cannot be purchased easily.

The NCFH "HIV/AIDS Farmworker Fact Sheet" notes the following regarding high risk behaviors among MSFWs:

- "Some labor camps are composed primarily of single males. This factor, combined with very limited recreational facilities, social isolation, and cultural sanction of prostitution, has resulted in a high incidence of sexually transmitted disease in these camps."

- "A high incidence of both prostitution and intravenous (IV) drug use has been observed within some farmworker communities, especially in the East Coast Migrant Stream, where single migrant men interact with day-haul workers from large cities with large IV drug-using populations."

- "…A more common risk behavior is unprotected sex, and more particularly, patronage of a prostitute. Kurt Organista conducted a survey that found 44% of the 342 male respondents had sex with prostitutes while working in the United States." The grower, farm owner or crew leader may bring sex workers to the farm.

- In an article published in the *American Journal of Community Psychology* in 2000, Kurt Organista noted that the literature indicates low and inconsistent condom use, as well as low levels of knowledge regarding proper condom use, among MSFWs. "Fewer than half had ever used condoms, and of those that had been sexually active during the previous year, less than a third had used a condom each time. Seventy-five percent (75%) almost never carry condoms."

- "Mexican migrant women, as well as the wives of migrant men back in Mexico, are at risk for HIV due to risky behaviors of their male sex partners….One study found that 75% of 159 female migrants reported never carrying condoms. Many believed that carrying a condom would be perceived as a sign of promiscuity."

Hard data regarding HIV seroprevalence among MSFWs in New York State is not available. While key informants observe relatively low numbers of known HIV infected persons in need of treatment, they acknowledge the existence of the risk factors described above and the fact that knowledge of HIV status and testing rates are low among this population.

Multiple Factors Contribute to HIV Risk and Poor Health Outcomes Among Migrant and Seasonal Farmworkers

There are multiple factors contributing to HIV risk and poor health outcomes among farmworkers and their families. In addition to the high risk behaviors discussed in the previous section, these include:

FEAR OF DEPORTATION

Over 90% of migrant and seasonal farmworkers are foreign born, and many would like to secure legal status in the United States. Farmworkers may refrain from HIV testing and utilizing HIV- related services due to fears of being deported, being labeled a public charge, or otherwise jeopardizing their current or desired status relating to becoming a legal permanent resident and/or naturalized citizen.

SURVIVAL NEEDS

Farmworkers are compelled to focus on basic survival issues such as securing and maintaining employment and housing, with little time and opportunity to seek out prevention and health care services.

CO-MORBIDITY FACTORS

These factors are often present in the daily lives of MSFWs resulting from the nature of their work and living conditions:

- Exposure to pesticides;
- Unsanitary and unsafe working conditions that may lead to injuries;
- Poor living conditions that contribute to weakening of the immune system;
- The socially and culturally acceptable use of alcohol; and
- Transmission of communicable diseases, such as Tuberculosis and Sexually Transmitted Diseases (STDs). In one study, 9% of Mexican farmworkers reported having at least one STD during their lifetime (NCFH "HIV/AIDS Farmworker Fact Sheet," n.d.). This is significant because the presence of STDs can increase an individual's susceptibility to HIV infection.

LACK OF KNOWLEDGE AND FALSE PERCEPTIONS

The NCFH "HIV/AIDS Farmworker Fact Sheet" cites data from a 1998 survey by K.C. and P.B. Organista, noting that misconceptions were common: 44% thought mosquitoes could transmit AIDS; 37.5% thought transmission was possible through public bathrooms or kissing; 25% thought AIDS was solely a problem for homosexuals and drug addicts; and 20% felt they could determine if someone was infected by physical appearance, and the test for HIV could cause AIDS.

This data underscores the fact that there is a scarcity of culturally and linguistically appropriate HIV educational materials and prevention messages designed specifically for farmworkers and an urgent need to address this gap. Given the average sixth grade education level among MSFWs and their cultural diversity, the lack of low literacy, language appropriate HIV/AIDS materials makes it particularly difficult for farmworkers to become fully informed about HIV/AIDS and how to prevent infection.

STRUCTURAL AND INSTITUTIONAL BARRIERS

The literature documents various structural and institutional barriers that contribute to poor health outcomes for MSFWs. These can be summarized as follows:

- Farmworkers are more likely to be poor and lack health insurance, factors that diminish access and/or utilization of health and supportive services.

- Lack of culturally and linguistically competent organizational practices can result in poor communication between providers and consumers, sub-optimal utilization of health and social services and consequently poorer treatment adherence by farmworkers.

- Research and funding are lacking for the development of behavioral interventions specifically designed to address the HIV prevention and treatment needs of migrants. Capacity building is also lacking to bolster prevention and HIV-related services delivered by agencies targeting migrant and seasonal farmworkers.

- Non-traditional hours for the provision of medical and social services for farmworkers are not always available, and partnerships with growers are often lacking to enable easy access to medical providers, social services and preventive health education.

- The benefits of migrant and seasonal farmworker representation on advocacy groups and consumer advisory boards in the medical and social service delivery systems are not uniformly recognized. Such representation would help to ensure cultural sensitivity, identify barriers to care, and address the unique needs of MSFWs, including those who are HIV infected.

NEW YORK STATE PERSPECTIVE ON MIGRANT AND SEASONAL FARMWORKERS, HIV/AIDS, AND CHALLENGES IN ACCESSING HEALTH AND RELATED SERVICES

Introduction

To promote dialogue and understanding about how to best serve migrant and seasonal farmworkers, this chapter examines the experiences of migrant and seasonal farmworkers in accessing and utilizing HIV preventive and health care services in New York State and includes:

- Descriptions of the profile of migrant and seasonal farmworkers in New York State, the nature of the work they do, the impact of immigration policies and increased border enforcement, and a brief overview of the new day labor force.
- Information regarding HIV/AIDS knowledge, attitudes and behaviors and HIV testing.
- Identification of barriers to care that challenge migrant and seasonal farmworkers in obtaining needed services, and perspectives on unmet needs.
- Assessment of the quality of care, the importance of linguistically appropriate and culturally competent services, and promoting best practices.
- Description of existing New York State Department of Health programs serving MSFWs.

This section incorporates both primary and secondary data. Primary data includes findings from consumer and provider focus groups and surveys, and key informant interviews conducted recently in New York State. Secondary data from published sources and other documents has been utilized to identify trends, policies and best practices that can inform the dialogue about how to improve health outcomes and best serve the HIV prevention, care and support service needs of MSFWs in New York State.

FOCUS GROUPS AND SURVEY

Two focus groups of migrant and seasonal farmworkers and a provider focus group were conducted at two locations in New York State, and a survey was completed by some of the participants. This methodology was used to give workers and their providers a voice to share their experiences, perceptions and recommendations for improving services to

MSFWs. The information gathered through these methods is valuable as there is very little New York State-specific information published on this population.

A total of 39 farmworkers participated in focus groups and answered survey questions. The characteristics of focus group participants can be summarized as follows:

- 75% of participants were male and 25% female
- 87% Mexican, 5% Caribbean Black, 5% Central American, and 2% South American
- 95% reported Spanish as their primary language
- 48% of respondents were between the ages of 19 and 29
- 36% were between the ages of 30 and 49
- 89% reported being undocumented, 8.5% reported being legal permanent residents and 2.5% reported being U.S. citizens
- At the time of the survey, 74% were employed full-time, 18% had part-time employment and 6% were unemployed
- 51% reported being single or divorced, and 40% reported being married.

The HIV status of focus group members is not known. The decision to refrain from self-identification of HIV positive farmworkers in focus group discussions was based on advice from experts in the field. The experts consulted suggested that the high degree of HIV stigma (isolation by peers and family members) and fear of loss of employment due to HIV disclosure would deter individuals from participating and could possibly jeopardize the livelihood of individuals involved.

Data were derived from participants who attended the focus groups and filled out surveys. Because of the small, non-randomized sample of participants, this report does not attempt to arrive at wide reaching conclusions about this consumer group but rather seeks to contribute to a body of qualitative data that can help HIV service providers and policy makers better understand and address the health care and service needs of migrant and seasonal farmworkers, particularly those that are HIV positive.

Data collection instruments were designed with the objective of examining the prevention and health-related needs of migrants at crucial junctures in the continuum of care, as well as access barriers. It is important to clarify that not all respondents answered every survey question. Unless otherwise noted, the percentages cited for participant responses in this section are based on the actual number of responses to the specific question posed; several questions allowed for multiple responses.

KEY INFORMANT INTERVIEWS

To supplement information provided through focus groups and the survey, four key informant interviews were conducted in August, 2006 to obtain the perspective of the following three individuals who work directly with MSFWs, and one staff person from the NYS Department of Health AIDS Institute AIDS Drug Assistance Program (ADAP) who manages a contract focused on this population:

> Wilfredo Morel, Director of Latino, Community Relations & Peer Program, Hudson River HealthCare, Inc. (HRHC)
>
> James O'Barr, Migrant Health Coordinator, Northeast Region, Hudson River HealthCare, Inc.
>
> Wilson Augustave, Sr. HIV Case Manager and Community Health Worker, Finger Lakes Migrant Health Care Project (FLMHCP)
>
> Sue Wade, RN, BSN, Public Health Representative IV, AIDS Drug Assistance Program (ADAP), NYS Department of Health AIDS Institute

Key informants enhanced the New York State-specific provided in this report, and offered insights on the current situation faced by MSFWs in light of the highly publicized debate on potential changes in immigration policies and more aggressive border enforcement.

Most of the information obtained from these interviews confirms that gathered through the original focus groups and surveys. Key findings are woven into the narrative throughout the report.

Profile of Migrant and Seasonal Farmworkers in New York State, Immigration Policy Changes, and New Day Labor Force

AVAILABLE DATA AND NATURE OF WORK

Published data on MSFWs focuses primarily on national data estimates or samples of individuals involved in studies; little data is available specific to New York State. Cornell University issued "Facts on Farmworkers in New York State" in 2001, based on information provided by the New York State Departments of Education, Labor and Health. Excerpts from that report indicate:

- "Approximately 47,000 migrant farmworkers and their family members come to New York State each year. The majority of workers in New York are of Mexican origin. Most others come from Jamaica, Haiti, Guatemala, Honduras, Puerto Rico, the Dominican Republic, and other states within the United States."

- "Migrant workers live in almost every county in New York. They live in western New York along Lake Ontario and Lake Erie harvesting apples, grapes, and other fruits; in central New York planting and harvesting vegetables; in the Finger Lakes region trimming and harvesting grapes; in the Hudson Valley harvesting apples, onions, and corn; in the Champlain Valley harvesting apples; and on Long Island working in nurseries and harvesting a variety of fruits and vegetables."

- "Some migrant workers live and work on dairy farms and move frequently within the State. They often work 60- to 70-hour weeks and face the same poverty as workers who move from state to state."

- As of 2001, "380 labor camps were approved to provide housing for 7,314 workers. In addition, there were many camps with fewer than five workers and therefore not inspected by state officials. However, the number of farmworkers in need of housing exceeds the number of available housing units, and many workers must, on their own, find a place to stay."

- Most farmworkers are excluded from New York State's labor laws relating to disability insurance, a day of rest, overtime pay, and collective bargaining. Farmworkers are also provided lesser coverage than other workers under some New York State labor laws, including child labor, unemployment insurance, and health and safety protections. Even those farmworkers under contract who are entitled to certain protections may not seek them for fear of losing employment.

Additional observations from key informants:

- Confirmed that most farmworkers in New York State are of Mexican descent. In addition to the countries of origin noted above, they added Panama and Bangladesh, and indicated that African Americans are part of this workforce.

- Impressions are that about two-thirds of farmworkers are male, and that the age range is wide, from mid-20s to 60, with the population becoming younger. In the Hudson Valley, it is estimated that about half are between the ages of 25 and 44.

- Some workers, but not many, are here under special work VISAs (H2-A workers) which offer more protections and benefits; workers under such contracts in the Hudson Valley include but are not limited to: Jamaicans, Chinese and natives from Bangladesh.

- Work in the fields and orchards, harvesting crops and fruits such as apples, grapes, onions, corn and potatoes, is long and arduous. MSFWs in NYS also work at duck and poultry farms, particularly in Sullivan and Rockland Counties. The latter is often 24/7 with schedules that result in workers being sleep deprived.

IMMIGRATION POLICY CHANGES: IMPACT OF TIGHTENING BORDERS AND DEBATE ON POLICY

Most key informants sense that fear among MSFWs is heightened as a result of increased border enforcement and potential changes in immigration policies that could result in criminal sanctions and/or deportation. The workers now have a greater fear that they will be "picked up" by law enforcement. Growers are also fearful of government intervention. One key informant related a rumor that federal raids were about to occur. This rumor turned out to be unfounded but resulted in MSFWs hiding or going back home. Another key informant talked about increasing fear when MSFWs receive letters from government institutions, such as Social Security or Motor Vehicles; now, workers who receive such letters often immediately leave their jobs and move on.

A September 22, 2006 article by Julia Preston published in the *New York Times,* "Pickers are Few, and Growers Blame Congress," reports that "stepped-up border enforcement kept many illegal Mexican migrant workers out of California this year…The tightening of the border with Mexico, begun more than a decade ago but reinforced since May with the deployment of 6,000 National Guard troops, has forced California growers to acknowledge that most of their workers are illegal Mexican immigrants…Labor shortages have also been reported by apple growers in Washington and upstate New York." The article indicates further that "this year's shortages are compounding a flight from the fields by Mexican workers already in the United States. As it has become harder to get into this country, many illegal immigrants have been reluctant to return to Mexico in the off-season. Remaining here year-round, they have gravitated toward more stable jobs." The reporter notes that growers are mainly "blaming lawmakers in Washington for stalling immigration legislation that would have addressed the shortage by authorizing a guest-worker program for agriculture."

A key informant noted that in terms of accessing general health and supportive services, farmworkers continue to use services provided by his agency because it is known to them and trust has been established. In the current climate, a new community agency might have problems engaging the population.

NEW DAY LABOR FORCE

While not a primary focus of this report, it is important to note the existence of day laborers in New York State. The January 2006 report, "On the Corner: Day Labor in the United States," (Valenzuela, et al., 2006) profiles this relatively new national phenomenon. The report indicates: "Men and women looking for employment in open-air markets by the side of the road, at busy intersections, in front of home improvement stores and in other public spaces are ubiquitous in cities across the nation." This report is based on a survey of 2,660 day laborers in 20 states and the District of Columbia. The report indicates that across the nation on any given day, there are approximately 117,600 workers either looking for day-labor jobs or working as day laborers. Most day laborers were born in Mexico (59%) and Central America (28%); the third largest group (7%) were born in the United States. The top five occupations include construction laborer, gardener/landscaper, painter, roofer, and drywall installer. The report concludes that the

day-labor market is rife with violations of workers' rights, including denial of payment for work performed, hazardous job sites, and employer abuse.

A key informant advised that MSFWs who learn they are HIV infected may choose to stay in the location where they are receiving care and services, and often become part of the day labor force when agricultural work is not available.

Another key informant noted that most day laborers in New York's Hudson Valley are outside of the migrant stream, and almost all do not speak any English. The few that do speak English become de facto crew leaders and attempt to negotiate for the workers. He observed that there are numerous problems with this growing population, such as not getting paid for work done, being treated badly on the job, and job-related injuries. As these workers are not part of the migrant stream, funding and programs directed to migrant farm workers do not reach them, making them a very needy population. He noted the need to study this population in New York State, and put programs in place to reach them.

HIV/AIDS Knowledge, Attitudes and Behaviors Among MSFWs in NYS

Consistent with study data already cited, lack of knowledge about the prevention and transmission of HIV places MSFWs in New York State at high risk of HIV infection. Among focus group participants surveyed:

- 33% indicated that HIV is no longer a serious problem in the United States
- 32% believed that HIV affects only gay men and drug users
- 27% indicated that a person that looks and feels healthy does not have to be tested for HIV
- 24% believed that you can get HIV drinking from the cup of an infected person
- 13% believed that HIV/AIDS is curable
- 8% believed that you can tell whether a person has HIV or AIDS by looking at the person.

Two key informants related their sense that multiple sex partners and prostitutes present the greatest risk among the MSFWs they serve in New York State, and that condom use is not consistent. Lack of easy access to condoms and cost are likely barriers. Alcohol and drug use among MSFWs also place this population at risk for HIV transmission.

HIV Testing

Despite study data indicating considerably higher rates of HIV infection among farmworkers as compared to the general U.S. population, only 12 of 39 survey respondents reported being tested for HIV (31%). Of these, 42% had last tested for HIV more than two years ago.

Respondents were asked what motivated them to seek HIV testing. Most reported they had sex without using a condom and/or sex with a prostitute. Others reported having sex with a current or former drug user, and still others indicated they sought testing as a result of becoming ill and having a doctor recommend HIV testing.

Service providers indicated that many undocumented farmworkers in particular are reluctant to obtain HIV testing. One provider noted: *"I'm from Mexico and I can tell that the people who aren't documented feel afraid to be tested. That's why when we go do the outreach and teaching, a lot of them refuse to be tested because they feel like this is one way we can find out if they have papers."*

Unfortunately, due to time constraints, worker exhaustion (participants had worked all day) and a high level of illiteracy among participants, additional information about participants' HIV testing experiences, as well as the reasons why many had not sought HIV testing could not be obtained by focus group leaders.

A key informant indicated his sense that there is low awareness of HIV status among MSFWs, but observed that his center is seeing an increased willingness to test when workers are offered rapid HIV testing because they are able to learn the result at the same visit. Key informants reiterated the importance of a trusting relationship between the provider agency and the farmworker in order for testing to be considered. Another important observation is that MSFWs may avoid seeking HIV testing, care and services because of the stigma associated with HIV and the discrimination and isolation that could follow.

A 2002 study of 400 Latino/a migrant farmworkers in California conducted by the California Department of Health Services shows similar HIV testing rates (31%) and provides useful information about factors influencing migrant farmworkers decisions about HIV testing. The data are summarized on the following tables:

Study of Latino/a Migrant Farm Workers in Three (3) California Counties Reasons for HIV Testing	Raw Number	Percentage
Wanted to know their HIV Status	71	57%
The doctor suggested HIV testing	44	35%
Wanted to have a child	35	28%
Part of a STD or a routine medical check-up	32	26%
Someone else suggested HIV testing	25	20%
Thought they had been exposed to HIV through sex	14	11%
Partner wanted them to be tested	7	6%
Required by insurer/military service/court	4	3%
Partner was HIV positive	2	1.6%

Note: Only 31% (125/400) of the survey participants ever reported being tested for HIV. 111 respondents reported that their HIV tests were negative. Three (3) respondents were not sure about the test results and no one reported having a positive HIV test result. The total number of responses exceeds 125 because study participants were able to choose more than one reason.

SOURCE: Renato Littaua, Vanessa Miguelino, Travis Sanchez and Arsen Aslanyan, HIV Testing Behaviors Among Latino/a Migrant Farm Workers in Three California Counties (power point presentation: Office of AIDS, CA Dept. of Health Services, Division of HIV/AIDS Prevention/National Center for HIV, STD, TB Prevention/Centers for Disease Control and Prevention, University of CA at Berkeley, 2002) p. 8, document on file with the author.

Study of Latino/a Migrant Farm Workers in Three (3) California Counties Main Reasons for Not Testing in the Past Year	Raw Number	Percentage
Were sure that they were HIV negative	219	84%
Perceived as unlikely that they could have been exposed to HIV	178	68%
Did not know about where to get tested for HIV in their area	99	38%
Did not have time	47	18%
Did not want to think about being HIV positive	39	15%
Did not want to upset their family members	32	12%
Afraid that they could be HIV positive	29	11%
Friends would react badly	26	10%
Worried that their name would be reported to the government/police, etc.	23	9%

Note: 65% of the survey participants (260/400) reported that they had never tested for HIV. The total number of responses exceeds 260 because study participants were able to choose more than one reason.

SOURCE: Renato Littaua et al, HIV Testing Behaviors Among Latino/a Migrant Farm Workers in Three California Counties, p. 10, document on file with the author.

Lower rates of HIV testing among MSFWs mean that individuals who are infected most likely learn their HIV diagnosis at later stages of disease progression, making treatment more difficult. Opportunities for early intervention including medications are diminished. These circumstances are especially disconcerting given that for those testing HIV positive, early access to HIV treatment can help strengthen their immune systems and reduce the risk of serious disease-related complications.

Barriers to Care and Unmet Needs

BARRIERS TO CARE

Focus group participants and key informants provided insight on barriers MSFWs face relative to seeking care and related services. The barriers fall into the following general categories: lack of time; cost and lack of health insurance; no transportation; language; fear and mistrust; and frequent mobility.

Two key informants emphasized that the number one priority for MSFWs is working to generate income, and most will seek medical care only if badly injured or very sick. Another provider noted: *"Because migrant farmworkers move around a lot and work many hours, they do not access care on a regular basis."* In fact, more than one-quarter (26%) of survey participants reported they had not seen a doctor in more than two years, and another 17% reported it had been more than one year since their last health care visit.

The leading barriers to accessing health services were identified by focus group participants:

Can't take time from work	(20%)
Can't afford to pay for services	(18%)
Transportation problems	(18%)
Can't understand the provider/doctor	(15%)
Don't think I will be understood	(13%)
Concerned about being mistreated or disrespected	(5%)
Fear of being deported	(4%)
Other miscellaneous reasons	(7%)

The toll of their work on the lives of MSFWs -- the arduous nature of farmwork, poverty status, crowded living arrangements, poor working conditions and regular travel across state lines into relatively unfamiliar areas -- cannot be underestimated. Factors such as the high cost of health care combined with fear of losing one's job, loss of pay, and the responsibility of having to provide for family members in their native countries weigh heavily on the shoulders of farmworkers. One focus group participant noted:

"Many times a sick person won't go to the doctor for fear of losing his job. In addition there are never sick days available. If you have to send $300 to family back in Mexico each month, you can't afford to lose not even one day of work. If you do not go to work, you don't get paid. So you endure your pain -- you endure whatever it takes because you don't want to lose your $50."

In some instances farm owners prohibit health and other service provision on-site at farms or camps and are reluctant to release a worker for a doctor's visit. Workers fear employer reprisals for taking sick time. As noted by one provider:

"We have a big problem with owners. Some of them don't want their workers to leave the job to come to the clinic. Sometimes I have to go myself and say, 'You know, he needs to see a specialist. He's sick and if you want him to continue working for you, you better let him go'."

Other providers shared this concern, noting that few state- or county-sponsored medical and social services are offered after hours and on weekends. As the harvest draws to a conclusion, the hours become longer with some MSFWs working five am to midnight. Exhaustion of the workers makes it less likely they will seek services. One focus group participant noted:

"The other day I went to see the doctor; it was 2:45 pm when I finally saw him. He said, 'We have to finish quickly because I leave at 3:00 pm.' I thought to myself, he should be more ethical – what would it cost him to take fifteen extra minutes to fully attend to his patient?"

Seeking health care services is financially prohibitive not only because of uncompensated or unauthorized work leave, but also due to lack of health insurance and the high cost of health care and medications. Generally, lack of health insurance is one of the major barriers to accessing health care services, and the overwhelming majority of farmworkers are uninsured. In 2000, 85% of migrant and seasonal farmworkers and their families were uninsured, compared to 37% of low-income adults nationally (Rosenbaum and Shin, 2005).

Since migrant workers often move from state to state within relatively short periods, accessing Medicaid and other public benefits is especially challenging due to several factors:

- Ineligibility relating to citizenship, residency or other criteria;
- Differing state eligibility requirements for Medicaid and public benefits;
- Lack of familiarity with local social service agencies that can assist migrant farmworkers with public benefit applications;
- Language and literacy barriers;
- Lack of transportation;
- Long work days and lack of sick and personal leave to attend appointments;

- Lack of knowledge regarding where services are located and which agencies provide what services, and
- Confidentiality concerns.

Data from the Kaiser Commission Report (Rosenbaum and Shin, 2005) present a compelling picture of the dire financial situation of MSFWs. In 2000, the median income for migrant and seasonal farmworkers was $6,250, compared to $42,000 for US workers overall. Although 59% of MSFWs lived below the poverty level in 2000, 85% had no health insurance at all. Only 5% reported coverage through Medicaid, and 10% reported private health insurance coverage. Nearly 90% of the children of migrant and seasonal farmworker families were uninsured compared to 22% of all low income children that year. Many focus group participants identified high health care costs as a major deterrent to seeking health services:

"If they are going to charge us what only a rich person can pay, we won't be able to use health services. It's unjust – payment should be according to what you earn, a percentage of your earnings."

In addition, workers will most often require help navigating the health care system if they need to access testing or specialty care. Concrete needs must be addressed, including transportation, translation and escort services. Key informants emphasized the importance of taking medical care and other services to the workers through mobile vans and on-site clinics whenever possible. Employing bi-lingual staff and arranging for translation are essential elements of any program dedicated to serving MSFWs.

Fears associated with undocumented status, loss of job, being reported to the Immigration and Customs Enforcement (ICE) Section of the U.S. Citizenship and Immigration Service (formerly known as INS), and being deported are other major deterrents to seeking care and services from institutions associated with government agencies. Lack of trust is a primary barrier; agencies and programs that effectively deliver services to this population are those that develop trust with MSFWs.

Key informants advise that additional barriers are created by lack of cultural sensitivity in relation to multiple languages spoken by MSFWs; differences in cultural norms, religion, and values; alternative medicine beliefs; as well as family relationships and the variety of living situations and backgrounds of MSFWs. Recruiting community persons who can identify and communicate with the workers is essential to engaging this population.

Even when a migrant worker has a diagnosed condition for which he/she is receiving treatment, that can easily change when moving on to the next job. The lack of a coordinated network of migrant-friendly clinics across states and in countries of origin and the time-intensive nature of arranging for care at the next job site makes continuing care in a new location not likely in most instances. As noted by one focus group participant: "*There is little information about clinics when you move from one state to the other. If you don't hear from anyone, you don't know."* A key informant noted: *"If a migrant worker is engaged in services, then leaves, he often returns in desperate shape."*

Stigma, fear of discrimination, and loss of job are very powerful deterrents to seeking HIV testing and treatment. As one provider observed:

"If co-workers were to see him (the farmworker) speaking to the HIV/AIDS counselor, they would immediately identify him as HIV positive, leading him to be an outcast, humiliated and even fired from the job. Migrants are also aware that they might not be employed again if anyone finds out that they are HIV positive."

One provider related the story of taking an ill Puerto Rican migrant worker in for medical attention that subsequently showed he was HIV positive. When the worker recovered and returned to the migrant camp, he discovered that the other workers had burned all his clothes and bedding and let it be known he was not welcome in the camp.

Without health insurance and easy access to primary care, farmworkers are less likely to receive HIV prevention education or to be screened for communicable diseases such as HIV, sexually transmitted diseases, and tuberculosis, and receive appropriate care. Federal and state grants available in New York State support HIV testing, care and support services for MSFWs, although it may not always be accessible for the reasons noted above. In particular, access to life-saving medications for HIV infected farmworkers will vary widely as migrant workers travel across state lines. New York State's AIDS Drug Assistance Program (ADAP) is relatively easily accessible to MSFWs through HIV service providers in the community. This is often not the case in other States that have more limited drug assistance programs.

UNMET NEEDS

When asked about priority unmet needs of MSFWs, key informants identified the following based on their direct interaction with this population in NYS:

- Adequate health care, housing and transportation.
- Access to specialty care and dental care.
- Additional interpreters, care advocates, prescriptions (in addition to those covered by ADAP), and health education information primarily for Spanish-speaking populations and in other indigenous languages.
- For HIV+ workers, more easily accessible legal assistance to address citizenship issues so they are not fearful of seeking health care and services as they migrate. The limited amount of money available for legal services has been cut in many areas of the State.
- Depression and anxiety are prevalent among this population in general – most are undocumented, work very hard for low wages, and miss family. If HIV is layered on, it is extremely difficult for them to cope. There is a need for counseling and supportive services for MSFWs, recognizing that it is very difficult to provide these services on a continuing basis because the workers move around so frequently.

- Improved coordination among the few agencies that serve this population across the states and in countries of origin to ensure that needed care and services are delivered.
- On-going HIV prevention education targeted to MSFWs.
- Hard data on the number and profile, including HIV status, of MSFWs in New York State, as well as the growing population of day laborers, to document their presence and needs.

Quality of Care and the Importance of Linguistically Appropriate and Culturally Competent Services

QUALITY OF CARE AND CONSUMER SATISFACTION

Focus group participants were asked to identify their primary source of health care services. The overwhelming majority identified community health or migrant health care clinics as their primary source of care (59%), followed by private doctors (22%), hospital emergency rooms (11%), mobile health vans (4%), and doctors visiting the labor camp or residence (4%). (It is important to note that since focus group participants were recruited within the catchment area of a migrant health program, this response is probably not reflective of the more general MSFW population who, when ill, most often seek care at a hospital emergency room.)

In some cases, community and migrant health centers may not be able to keep up with the demand for services as observed by one focus group participant: *"Sometimes the clinic is overcrowded and you have to wait for weeks to be seen, so you have to go to the emergency room."* Service provider respondents acknowledged a relatively high rate of emergency room visits by farmworkers, indicating that 67% of their clients sometimes use emergency rooms as their source of health care.

Participants were asked to rate their overall health and level of health care satisfaction;

- The majority of focus group participants (54%) rated their health over the past year to be "fair to poor."
- Twenty-nine percent (29%) reported dissatisfaction with the quality of care they received at their last visit.

The leading causes of dissatisfaction with the quality of care received were as follows:

- The doctor or provider made me wait a long time. (33%)
- The doctor or health provider did not speak my primary language. (25%)
- The doctor or health provider did not give me medicine to help me. (17%)
- The doctor or provider did not listen to my health concerns. (17%)
- The doctor or health provider did not explain what was wrong with me in a way I could understand. (8%)

Providers limit opportunities for patient education and treatment compliance when they fail to recognize and address the needs of their patients who have limited English proficiency. One focus group participant noted frustration about the rushed nature of patient-provider interactions: *"I was hospitalized for three days and when my doctor would come to see me he would spend only four minutes with me and that included the time the translator took to translate the questions and answers."* Another participant noted: *"We don't have information about treatments. Personally I would like to know more."*

The reasons cited as sources of consumer dissatisfaction underscore the need to reduce institutional barriers such as:

- Long waiting times for appointments
- Scheduling that does not include adequate time for effective provider/patient communication
- Lack of linguistically appropriate services and inadequate provider communication patterns that fail to take into account factors such as the need for translation services, cultural differences, and low literacy levels.

Even when migrants are able to access care, the lack of a comprehensive health care infrastructure and adequate provider training can seriously hinder the quality of care received by migrant farmworkers. The major U.S. migrant health initiative known as the Migrant Health Program is operated under auspices of the Bureau of Primary Health Care of the U.S. Department of Health and Human Services. It is generally acknowledged that this initiative reaches a relatively small percentage of the total migrant population. One provider noted that often times even migrant health programs are ill-equipped to serve farmworkers with HIV/AIDS: *"Along the stream, migrant health clinics are available. However, they often don't have AIDS-related services, and the doctors may not be familiar with the most effective protocols."* Building a continuum of comprehensive HIV care across state lines is vitally important, as suggested by the comments of one provider:

"Migrant Health Centers are available in different states up and down the stream; however, some states have more developed programs than others. Many of these clinics do not have HIV/AIDS specific services. Not having the AIDS Drug Assistance Program (ADAP) or HIV/AIDS specific services may be very significant in health outcomes for migrant and seasonal farmworkers who are HIV positive. A client may not be able to get appropriate blood work and the medications s/he needs may not be available. This means that treatment is often discontinued and clinics/services in New York become the primary care provider. For a worker who may be in New York for only one-two months, because what he does is harvest apples, this might mean that he only receives adequate HIV/AIDS-related care during that short time."

The scenario depicted above is very concerning given that disruption in care can lead to HIV disease progression, and lack of consistent access to medications can cause a person to become drug resistant to life enhancing HIV medications. In addition, numerous studies have shown that HIV positive individuals with a regular source of health care are

more likely to receive antiretroviral therapy and reduce the risk of hospitalization than those without a regular source of care.

IMPORTANCE OF LINGUISTICALLY APPROPRIATE SERVICES

Less than five percent of Mexican-born and other foreign-born Hispanic farmworkers in the NAWS Survey (2001-2002) reported they could read and speak English well. Language barriers between provider and patient can lead to a multitude of problems including incomplete medical histories of patients, misdiagnosis, unnecessary tests, missed opportunities for patient education, poor patient compliance, nonadherence to prescribed medications and/or not taking medications according to instructions, higher levels of patient dissatisfaction, underutilization of health services, and treatment failure (Woloshin, et al., 1995).

For example, a study published in 2002 showed that 27% of hospital patients with limited English proficiency who did not receive interpreter services left the hospital without understanding how to take their medicines, compared to just 2% of those who did receive interpreter services (Andrulis, et al., 2002).

Ninety-five (95%) of survey respondents in New York State indicated that Spanish was their primary language. As noted earlier, 25% of survey participants who reported being dissatisfied with their health care services cited, "the doctor or health provider did not speak my primary language" as one of the causes for their dissatisfaction. In 17% of the cases requiring translation, no translation services were provided or available.

Even when available, the translation in many circumstances was provided under less than optimal conditions. More than one-third of respondents had to rely on non-medical personnel for translation, such as a neighbor or relative (29%) or clerical staff (13%). These circumstances can result in high levels of patient discomfort especially when discussing sexual histories. One female focus group participant emphasized this point: *"It would help to have women interpreters because with a male interpreter, you can get some assistance, but it's not the same kind of trust. I would be happy with a female interpreter."*

Without the provision of linguistically appropriate services, the quality of care for HIV-infected farmworkers will continue to be inconsistent since provider and patient will be unable to communicate effectively and work in partnership to manage the disease. Therefore it is imperative that the HIV/AIDS service delivery system develop the capacity to provide linguistically appropriate services in order to deliver high quality, state-of-the art services to migrant and seasonal farmworkers.

IMPORTANCE OF CULTURALLY COMPETENT SERVICES

Providing linguistically appropriate services is only one component of delivering culturally competent services. Cultural competence in health care delivery requires providers to understand the beliefs, values, traditions and practices of a cultural group, including culturally-based beliefs about the etiology of illness and disease, and about concepts of health and healing practices. Other socio-cultural factors must be taken into consideration as well, including migration, sexual orientation, socio-economic and educational background, and religion, which help to shape an individual's values, beliefs, perceptions and behaviors (Betancourt, et al., 2002).

Understanding healing practices, traditions and beliefs is particularly important in the case of migrant farmworkers. Many migrant farmworkers are either unaccustomed to or distrust western medicine approaches, or simply cannot afford to pay for health care. Therefore, they may rely on home remedies and other alternative therapies to treat illness and improve health (Dobkin de Rios, 2002). Among survey respondents, 35% reported seeking health services or advice from alternative health providers or using complementary therapies, and 30% reported visiting folk or cultural healers. Developing alliances with and educating these important community resources is an important step in the fight to stem the tide of HIV/AIDS among migrant farmworkers and their families.

Understanding cultural beliefs is central to developing effective HIV/AIDS prevention messages and promoting safer sex practices. For example, several researchers have suggested that HIV/AIDS prevention and education messages should be adapted to prevailing culture-based gender roles. Dr. Kurt Organista, one of the leading researchers on migrant farmworkers, observes:

"Mexican migrant farmworkers commonly acknowledge the practice of 'macho men' having sex with men but stopped short of admitting any such personal experience. The risk to the female partners of males who engage in high risk, unprotected sex with other men needs to be acknowledged. The culture-based responsibility of protecting one's woman from a fatal disease should be stressed. One study showed using condoms to protect one's female partner was a more powerful predictor of condom use than self protection in Mexican immigrants."

Dr. Organista's observations provide a powerful example of how cultural beliefs and norms can influence individual behavior and why cultural knowledge is crucial to designing effective HIV/AIDS services. For many farmworkers, the terms "gay" or "bisexual" are meaningless because man-to-man sex is seen in terms of gender roles with the insertive partner being the "male" and the receptive being the "female." Among farmworkers, the "female" partner must endure abuse and isolation. A provider relayed an example from one migrant camp where the "female" male partner was forced to live in a shed for animals separate from the other workers even though he was having a sexual relationship with one of the male migrant workers.

Promoting Best Practices: Common Elements of Successful MSFW Programs

In general, there is little information in the public health literature concerning best practice models for the delivery of HIV prevention, health and social support services for at-risk and HIV-infected farmworkers. Providers who serve migrant and seasonal farmworkers indicate the following elements are particularly important for successful service delivery:

Trust Building, Peer Leadership and Employment: To establish trust and design services that are truly migrant-friendly, organizations must be commited to the authentic involvement and equitable representation of migrants and persons who identify with MSFWs in the design and delivery of services and in decision-making and policy-setting within the organization. Persons who have done this work and peers who can identify with MSFWs are best able to communicate with them, listen to their concerns, and follow-up to be sure workers understand what they have heard from providers and in health-related messages. Such programs are able to convey a deeper understanding of the challenges faced by farmworkers, are better able to craft effective interventions, and to assure workers that confidentiality will be protected.

Attention to Survival Needs: The most successful organizations are those that commit resources to addressing the basic survival needs of migrant workers and advocating on their behalf. These needs include legal services addressing immigration status, housing and nutrition assistance, employment and vocational training, and accessing public benefits. Often, these services must be coupled with transportation, translation and escort services. These organizations actively participate in social justice campaigns that seek to affirm the human rights of farmworkers and address the systemic and institutional barriers they encounter, including but not limited to: low pay, poor working conditions, inadequate housing, no health insurance, and varying eligibility for services across state lines.

Location of Services, Transportation and 24-Hour Availability: Long working hours and lack of transportation are considerable barriers to seeking assistance and care. Successful programs are more likely to bring services to the workers through mobile vans or on-site clinics, to provide transportation to and from services, to provide services outside of normal business hours, to limit waiting time, and to provide information and referrals through a 24/7 toll-free, bi-lingual hotline.

Cultural Competence: Culturally competent organizations and programs strive to develop and implement policies and practices that are based on an understanding and respect for different cultural values, beliefs, norms, religions and experiences. These programs integrate an appreciation of this diversity into the design and delivery of services. An essential component of culturally competent services is the provision of linguistically appropriate services.

Linguistically Appropriate Services: Essential elements include a commitment to hiring multi- and bi-lingual staff to ensure effective provider/patient communication, culturally and linguistically appropriate materials in all areas (e.g., outreach and educational materials, intake forms, referral information, office signs, website, etc.), and innovative solutions to maximize access to services for consumers with limited English proficiency (e.g., English as a second language classes, peer translators/advocates, etc.). Linguistically appropriate services help patients understand their medication regimen and the importance of treatment adherence. When translation services are used, they must address confidentiality concerns.

Intensive Outreach, Case Management, and Comprehensive Health and Supportive Services: Most MSFWs work and live in New York State for short periods of time. This requires programs to engage in intensive outreach, including frequent visits to labor camps and other locations where farmworkers live and/or congregate. Successful programs include intensive case management that helps MSFWs navigate complex health and social service delivery systems, and empowers them to seek services on their own whenever possible. Comprehensive services encompass access to a full range of services: preventive and primary health care; access to medications through the AIDS Drug Assistance Program (ADAP); specialty care; medical and laboratory tests; dental services; and nutrition assistance. Programs must also address the supportive service needs of MSFWs, including counseling and mental health services to address anxiety and depression associated with this work and separation from family. These services are particularly important for farmworkers who are also dealing with the stigma associated with HIV infection.

Population-Specific Outreach, Education and Programming: Farmworkers tend to have low literacy rates and speak different languages and Spanish dialects. Therefore, outreach strategies, educational materials and programming must take these factors, as well as the age of the target audience, into account. Effective approaches include: utilizing Promotora/os de Salud (promoters of health), a form of one-on-one peer outreach and education, the use of Spanish language radio and television for the dissemination of HIV prevention messages, fotonovelas (similar to comic books), house parties with games and Campesino Theatre (interactive theatre addressing HIV/AIDS with the audience role playing and problem solving).

Inter-State and Bi-National Coordination and Service Linkage: Given the high mobility of farmworkers, effective programs must have in place a sophisticated inter-state and bi-national system for coordination and service linkage that will allow HIV-positive clients to continue to receive uninterrupted service as they travel from state to state and back to their country of origin. Using the resources and website of the National Center for Farmworker Health, which maintains a list of community health centers and resources from countries of origin, has helped some NYS programs ensure service linkage across state lines. In addition, one NYS program has established a bi-national exchange with providers in Mexico, although not all can provide medications and a full range of services. Advocating for Medicaid coverage that crosses state lines is a critical element of ensuring continuous care for MSFWs.

Skills Building: Emphasis is placed on skills development and the adoption of behavioral strategies to support primary and secondary HIV prevention and treatment adherence. Teaching strategies must be grounded in the experiences and circumstances of migrant farm communities.

Combating Stigma and Discrimination: Organizations must be knowledgeable about the multiple and overlapping forms of stigma and discrimination faced by migrants and have an institutional commitment and demonstrated practices (reflected in policies, staffing, funding allocations, client involvement and satisfaction levels) of combating stigma and discrimination within and outside of the agency.

Existing New York State Department of Health Programs Serving Migrant and Seasonal Farmworkers

> *"New York's 30,000 migrant/seasonal farmworkers are an indispensable part of the state's $3 billion agricultural industry and it's imperative that these workers and their families be afforded quality health care."* (Governor Pataki, March 6, 2002)

The New York State Department of Health uses a combination of federal and state funds totaling over $1 million to support programs that focus on improving health status and quality of life for MSFWs and their families. Some funded agencies also receive direct federal funds to serve this population. The first program described below is a general health program managed within the Division of Family Health; the second, managed by the AIDS Institute, emphasizes HIV prevention and health care. The following information was provided by managers within these two organizational units of the NYS Department of Health (NYSDOH).

NYSDOH MIGRANT AND SEASONAL FARMWORKER HEALTH PROGRAM

The Migrant and Seasonal Farm Worker (MSFW) Health Program provides funding to 15 contractors including: seven county health departments, three community health centers, one hospital, a day care provider with 12 sites statewide, and three other organizations. Services are delivered in 28 counties across New York State**.** A list of these contractors is attached as Appendix A to this report.

Each contractor provides a different array of direct and enabling services that may include outreach, primary and preventive medical and dental services, transportation, translation, health education, and linkage to services provided by other health and social support programs. The enabling/support services are designed to reduce the barriers that discourage migrants from obtaining care such as inconvenient hours, lack of bilingual staff and lack of transportation. Health screening, referral and follow-up are also provided in migrant camps.

The objectives of funded providers include:

- Leading the development of a comprehensive local response to the health and human resource needs of the MSFW population and their families.
- Providing access to health and human services for MSFWs and their families.
- Providing health education to MSFWs and their families in their native language that is culturally sensitive and promotes optimal health.
- Providing primary and preventive health care to MSFWs and their families.

During 2004, the following statistics were reported by contractors under this program:

- 8,250 adults and 5,410 children received medical/dental and enabling services
- 3,800 screenings for HIV/AIDS, STD and TB
- 2,700 screenings for vision and hearing
- 13,800 screenings for blood pressure
- 2,600 immunizations
- 9,900 health education encounters
- 19,000 home visits
- 6,000 instances of transportation
- 16,000 instances of translation/interpretation

In addition, the MSFW Health Program has partnered with the NYS Immunization Program to increase immunization rates in this population. Project goals include educating adult MSFWs on the benefits of immunizations and increasing the supply of vaccines to MSFWs via local health departments. Currently, this effort results in the provision of immunizations to MSFWs at 21 sites in 27 counties.

HIV/AIDS PREVENTION AND HEALTH CARE FOR MIGRANT AND SEASONAL FARMWORKERS

The goal of the HIV Prevention and Primary Care Initiative is to reach and serve high-risk, underserved populations in order to prevent HIV infection and provide accessible, high quality, comprehensive health care and supportive services for those who are HIV infected. Five agencies, including a migrant health project, two community health centers, a county health department, and a community-based organization, are funded to focus in whole or in part on providing a range of HIV prevention and health care services for MSFWs, which can include all or some of the following services:

- Targeted outreach, most often by peers or community members who can identify with MSFWs
- HIV prevention education
- HIV counseling and testing, including rapid testing
- Primary medical care including screening for STDs
- Assistance in enrolling in the AIDS Drug Assistance Program (ADAP), which is accessible to all migrant and seasonal farmworkers in NYS.

- Access to specialty care, radiology, laboratory tests, prenatal care, and mental health services as needed
- Dental care
- Transportation
- Translation
- Case management, including linkage to care in other locations
- Counseling and peer support

The funded agencies deliver services to farmworkers whenever possible on mobile vans and on-site clinics, and at unconventional hours. They report serving individuals of diverse backgrounds, including Mexicans, Jamaicans, Haitians, Guatemalans, other Central and South Americans, Africans, and African-Americans. The agencies**,** listed in Appendix B of this report, are located in areas where there are significant numbers of MSFWs: the Hudson Valley, Long Island and the Finger Lakes Region.

CONCLUSION AND RECOMMENDATIONS

Migrant and seasonal farmworkers are more likely to be poor, to face numerous obstacles in accessing health care services, and to abstain from or delay HIV testing and therefore learn of their HIV diagnosis at later stages of disease progression. Information gathered indicates that a significant proportion of MSFWs experience discrimination and are dissatisfied with the quality of health care services received. Limited available study data indicate that HIV/AIDS is escalating among migrant and seasonal farmworkers and could have a devastating impact on this population and their families unless immediate steps are taken.

In an effort to address these concerns, recommendations are offered below, grouped into categories based on findings of this report. Deep appreciation is extended to farmworker focus group participants who openly shared their experiences and offered thoughtful recommendations with the hope of improving prevention and health-related services. Appreciation is also extended to service providers who participated in the provider focus group and key informant interviews, and offered insights concerning gaps in services, challenges faced by HIV positive farmworkers, and how to address these issues.

The following recommendations are based on the valuable input provided by all of these individuals, as well as information contained in the numerous reference materials listed at the end of this report. **It is important to emphasize that implementation of these recommendations will be fully realized only if significant increases in public and private funding dedicated to services for migrant and seasonal farmworkers are made available.**

ESTABLISHING TRUST, CULTURAL COMPETENCE, AND ADDRESSING HIV STIGMA AND DISCRIMINATION

Gaining the trust of migrant and seasonal farmworkers is of primary importance to truly serve and engage this high-risk, underserved population. Among undocumented MSFWs, fear relating to immigration status is common. Providers have observed that fear is heightened as a result of increased border enforcement, potential changes in national immigration policies, and recent increased public attention to these issues. Another source of fear is the HIV-related stigma and discrimination that exists among farmworkers and growers as evidenced by accounts regarding loss of employment, cruel acts and severe isolation of infected workers. Since the overwhelming majority of MSFWs are foreign-born, it is essential to employ staff and design programs that reflect this diversity and respect different cultures and backgrounds. The following recommendations are offered to engender trust, emphasize the importance of cultural competence, and work toward elimination of HIV-related stigma and discrimination.

- Promote service models based on cultural competence that engender trust within the MSFW community, such as the following models used by a community health center in NYS. Peers and persons from the community who are bilingual or multilingual and can identify with farmworkers are employed in various roles, such as "Health Promoters," to remind workers of the need for health care and assist with transportation. "Patient Partners" assist in ensuring patients understand messages communicated by providers, and in keeping follow-up appointments. "Community Advisors" help deliver health promotion messages, link people with care at the community health center, and offer advice regarding program designs that will engage MSFWs. Meetings of Community Advisors frequently address topics of interest to MSFWs, such as immigration, housing, jobs, translation, in addition to health and HIV/AIDS topics, as an incentive for active participation. Such models increase the opportunity for active engagement of MSFWs in general health care and effective delivery of HIV prevention, care, and support services.

- Increase opportunities for MSFW representation on advocacy groups and consumer advisory boards associated with health and social services, by holding meetings at non-traditional venues and hours.

- Encourage collaborations among HIV/AIDS service providers and farmworker rights groups for the purpose of developing coordinated outreach strategies leading to connections to comprehensive health care services, including HIV prevention education and health care.

- Conduct "Know Your Rights" workshops bringing lawyers into the community to help farmworkers better understand their legal options and rights, and obtain legal services as needed.

- Develop an effective campaign to address HIV-related stigma and discrimination in MSFW communities. Without this sorely needed campaign, programs to increase access to HIV testing, care and support services will meet with limited success because of numerous fears associated with the devastating effects of stigma and discrimination, including loss of employment and severe isolation.

- Provide training and education for service providers in all disciplines and at all levels to enhance cultural competence and help them ensure linguistically appropriate services.

- Increase provider-sponsored cultural events that will attract MSFWs, integrating general health promotion and HIV prevention messages.

HIV PREVENTION, TESTING AND LINKAGE TO CARE

Surveys of farmworkers' knowledge of HIV transmission indicate lower levels of HIV-related knowledge than the general population. Also, less than one-third of survey respondents reported ever obtaining HIV testing services. These findings suggest the need to increase outreach, prevention and education activities, as well as to improve access to HIV counseling and testing. To achieve these goals, the following recommendations are offered:

- Increase support of community-based organizations with expertise in serving farmworkers for the purpose of conducting large scale, targeted outreach and developing HIV prevention and testing messages that focus on farmworkers and their partners.

- Promote HIV prevention and testing through the use of Spanish language and ethnic-identified radio and television programs, as well as Latino newspapers and magazines.

- Increase the availability of printed health education materials targeted to MSFWs, addressing HIV prevention and other health education topics, in multiple languages and dialects. (For example, some populations from the mountainous areas of Mexico speak different dialects.) Basic HIV educational materials addressing facts regarding HIV transmission and personal risk factors are needed for low literacy populations. Materials are also needed that target younger populations of MSFWs. These materials should be tested with the various target audiences before final printing.

- Increase condom distribution by all migrant outreach and provider staff to make condoms easily accessible.

- Develop culturally and linguistically appropriate "Know Your Status" campaigns which encourage early voluntary HIV testing and promote greater understanding of the benefits of early HIV testing in preventing and/or delaying the onset of HIV-related disease.

- Develop public education campaigns to inform migrant and seasonal farmworkers about the availability of HIV testing options, including rapid testing, and free or low cost treatment services, including enrollment in the AIDS Drug Assistance Program (ADAP) and/or other free or low cost health coverage.

- Hire and train bi-lingual and multi-lingual staff and peer educators that can conduct outreach, HIV prevention and HIV rapid testing among migrant farm workers of different cultural backgrounds.

- Create a toll-free hotline, accessible from Mexico as well, to help link migrant farm workers to needed HIV prevention, testing and treatment services.

ACCESS TO COMPREHENSIVE CARE, CASE MANAGEMENT AND ENABLING SERVICES

It is important for service providers, public health officials and policy makers to fully appreciate the life circumstances of migrant and seasonal farmworkers. Of necessity, their top priority is to work and generate income, and to do nothing that will endanger their continued employment or risk deportation. The programs designed to serve them must take into account these distinct realities while attempting to improve their access to comprehensive care and services. Towards this aim, the following recommendations are offered:

- Enhance the capacity of migrant and community health centers to provide comprehensive, timely primary health care services, including state-of-the-art HIV care, for migrant and seasonal farmworkers. Capacity-building should include enhanced resources to recruit, train and retain qualified and culturally competent personnel, and advance best practices. Comprehensive care should include direct provision of or linkage to primary and specialty medical care, dental care, and mental health services.

- Promote greater availability of delivery models that take services to the workers through mobile vans and/or on-site clinics held in settings that are easily accessible, offering services at lunch times, break times, and during the evening, and with minimal waiting time.

- Increase training for health care and social service providers and administrators so as to deepen understanding of the unique needs of farmworkers and their families, and to enhance cultural competence.

- Increase resources to make case management and enabling supportive services universally available to MSFWs, helping them meet survival needs. Such services include but are not limited to: transportation, translation, legal assistance and accurate information regarding immigration issues, housing assistance, English as a second language classes, food and nutrition assistance, employment and vocational training, and educational and supportive counseling.

TREATMENT ADHERENCE

On-going adherence support and counseling is essential for individuals infected with HIV/AIDS to achieve the full benefits of antiretroviral therapy (ARV). These benefits include: the preservation and/or restoration of immune function, improvement of overall health, the prolongation of life and the suppression of viral replication (Heath, et al., 2002). In the case of farmworkers, treatment and full medication adherence can be disrupted each time a worker travels to a new work location and must seek out a new health provider. Many migrant workers may not be fully aware of the serious consequences of discontinuing or not properly adhering to treatment recommendations and medication regimens. The following recommendations are offered to improve treatment adherence:

- Develop culturally competent adherence counseling programs specifically for farmworkers.

- Train health providers to effectively communicate with and counsel consumers on treatment adherence issues and management of side effects, providing translation services when necessary.

- Increase multi-lingual, low literacy, culturally competent educational materials on HIV disease, the importance of treatment adherence and the management of side effects.

- Provide best practice training on innovative treatment adherence support programs, especially those that include peer advocacy and support components.

- Ensure access across State lines to programs such as Medicaid and the AIDS Drug Assistance Program (ADAP), that increase access to lifesaving medications. (See Section on Policy Issues below).

QUALITY OF CARE AND SERVICES

Migrant health programs and community health centers targeting MSFWs are most often overtaxed, underfunded, and understaffed to meet the service demands of this diverse, high need population. Therefore, quality suffers and patients feel their health needs were not met. Further, if cultural competence and linguistically appropriate services are not evident, patients feel disrespected and are not likely to engage in care. To support migrant and community health centers' and community-based organizations' response to the challenges inherent in serving this population, implementation of the following recommendations is needed.

- Provide training and capacity building support so that migrant and community health centers and community-based organizations (CBOs) can improve and expand their service delivery to farmworkers in a sustainable manner. The training must encompass topics relating to cultural competence and linguistic diversity.

- Sponsor best practice conferences with providers throughout the East Coast Migrant Stream and subsequently publish and disseminate best practice monographs based on successful interventions.

- Provide training and technical assistance to migrant and community health centers and CBOs on conducting needs assessments specific to farmworkers, program planning and evaluation, and continuous quality improvement.

- Conduct consumer satisfaction surveys of patients and analyze available clinical and service data to make changes in program design and delivery that will improve the quality of care and encourage active engagement of MSFWs in improving their health status and obtaining necessary treatment.

- Identify recruitment incentives to attract qualified providers to migrant health careers, as well as strategies to retain providers in migrant health.

COORDINATING CARE ACROSS GEOGRAPHIC BOUNDARIES

Most MSFWs who come to New York travel along the East Coast Stream and work in multiple states from Florida to New England harvesting fruits and vegetables, or working on duck and poultry farms. The frequent mobility of migrant and seasonal farmworkers presents formidable challenges in ensuring care for workers who are HIV infected or have other chronic illnesses. Recommendations are offered below to help ensure care is provided when workers cross state lines or travel back to their countries of origin.

- Develop a national and international network of agencies that serve this migratory population so that care can be ensured for HIV+ and other chronically ill workers from state to state and in their countries of origin. A complete directory of these agencies and contacts must be easily accessible online and in print form.

- Adopt policies that allow medical services and medication, through Medicaid, the Ryan White CARE Act, and/or the AIDS Drug Assistance Program (ADAP), to be provided across State lines. (See section on Policy Issues below).

- Increase funding specifically for staff with case management skills whose job includes linking HIV-infected and other chronically ill MSFWs with health care and supportive service agencies as they migrate. Making these connections is very time-consuming for staff. Communication lines between these agencies need to be developed and refined to ease the time burden associated with linking MSFWs to necessary care and services.

- Pilot electronic transfer of medical records among health centers so that migrant workers are assured continuity of care.

DATA, RESEARCH AND PLANNING

Limited HIV/AIDS behavioral research and epidemiological information on farmworkers is available, making it difficult for service providers to design effective programs for this population. To address this problem, the following recommendations are offered:

- Explore the feasibility of establishing a data collection and reporting system to assess prevalence and trends in HIV/STD/TB disease and related risk behaviors among MSFWs. Ideally, this system should operate at state, national and international levels (with Mexico).

- Conduct special studies to better document the number and profile of MSFWs, risk and behavioral information, and rates of HIV seropositivity. The results of these studies, including HIV/AIDS epidemiological data and behavioral research information on MSFWs, should be widely disseminated to inform public policy decisions and the design of prevention and service interventions.

- Support collaborations between migrant and community health centers, CBOs and research institutions to investigate HIV/AIDS research topics of importance to farmworkers.

- Provide scholarship incentives to increase the number of researchers studying HIV/AIDS among farmworkers.

- Conduct special studies to learn more about the increasing number of dairy farmworkers, many of whom come from Mexico and Central America.

- Conduct special studies to document the plight of the growing new population of day laborers who are outside of the migrant stream, and therefore may be even more isolated and in need of services.

POLICY ISSUES RELATING TO IMPROVING OVERALL HEALTH STATUS OF MSFWs

To improve the overall quality of life and health status for migrant and seasonal farmworkers, policy issues must be addressed at the national, state and local levels. Concerted efforts of government officials, legislators, farmworker and public health advocates, and private funders are needed to address the following recommendations.

- Public policy decision makers must ensure that migrant and seasonal farmworkers are identified as a priority population in need of health care and supportive services so that adequate dedicated funding is provided for them. One convincing argument for investing in dedicated migrant/seasonal farmworker health care programs is to emphasize the broader public health impact if communicable diseases are not addressed within this population.

- National policy should establish reciprocity and portability in terms of MSFW eligibility for federally-funded medical care and HIV services across states, most notably those provided under Medicaid and the Ryan White CARE Act. The latter encompasses HIV care, access to medications through the AIDS Drug Assistance Program (ADAP), and enabling supportive services for HIV infected persons. The National Advisory Council on Migrant Health recommends “a

mechanism to ensure States comply with 42 CFR 233.40, which would allow a migrant farmworker who is temporarily working out of State to be eligible for Medicaid in the State in which he/she is working."

- Increased dedicated funding is needed to provide equitable access to health care and basic survival needs of farmworkers, regardless of immigration status. Cooperative efforts between public and private funders are essential to achieve adequate funding of comprehensive health and enabling services for this high need population.

- To improve MSFW overall quality of life and health outcomes, enlightened policies must be in place that address the following basic needs: increased pay for workers, health insurance coverage, improved housing and working conditions.

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Migrant Health Provider (Provider-Designated Contact)	Services / Other Contact(s)	County Served (+ NYSDOH Regional Office Liaison)
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Migrant Health Provider (Provider-Designated Contact)	Services / Other Contact(s)	County Served (+ NYSDOH Regional Office Liaison)
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AIDS Institute Contracts Providing HIV/AIDS Prevention and Health Care for Migrant and Seasonal Farmworkers

Appendix B

Finger Lakes Migrant Health Care Project, Inc.

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Counties Served :
Oswego, Wayne, Cayuga, Ontario, Yates, Steuben

Services Provided:
Case Management, Client Advocacy, Information and Referral, Transportation

Hudson River HealthCare, Inc.

Doug Capasso / HIV Director
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Peekskill, NY 10566

Ph#: (914) 734-8918
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Counties Served :
Westchester, Dutchess, Putnam

Services Provided:
HIV Counseling and Testing, HIV Service Coordination, Outreach, Support Group(s)

Ossining Open Door Family Health Center

Carol Lemus/Director, HIV Program
165 Main Street
Ossining, NY 10562

Ph#: (914) 491-1263
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Counties Served :
Westchester

Services Provided:
HIV Counseling and Testing, Outreach

Rural Opportunities, Inc.

Velma Smith/Senior Executive Director
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Monticello, NY 12701

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Counties Served :
Dutchess, Orange, Ulster, Sullivan

Services Provided:
Targeted Outreach, Enrollment in ADAP, Linkage to Care

Suffolk County Department of Health Services

Jean Wright/HIV Program Director
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Counties Served :
Suffolk

Services Provided:
Ambulatory Health Care, Case Management