

## MEMORANDUM

To: Kim Belshe, Secretary of California Health and Human Services Agency  
California State Assembly, Committee on Agriculture  
United Farm-worker Union  
From: Mikaela Kooiker, Policy Analyst, Health Access for California  
Date: December 20, 2007

### **Creating health care access for migrant farm-workers in California**

#### **Executive Summary**

Migrant farm-workers are vital to the Californian agricultural industry and economy. However, their poor access to health care services is contributing to deteriorating health status and rising public health concerns, which necessitate a change in public health policy. Possible alternatives addressed in this policy memo include: expanding public health insurance, mandating employers to provide health insurance or subsidizing employer-based health insurance, and increasing community outreach through mobile clinics. A combination of community outreach through mobile clinics and expanding public health insurance is recommended as the most comprehensive approach.

#### **I. Background**

##### ***Specification of the client and rationale for selection of the client***

This policy memorandum is addressed to three target clients: the Secretary of California Health and Human Services Agency, California State Assembly Committee on Agriculture, and the United Farm-workers Union. These three stakeholders were chosen through a stakeholder analysis (Appendix A) that identified them as the most influential and interested parties in making a difference to policy for migrant farm-workers in California. First, Kim Belshe, the Secretary of California Health and Human Services Agency, was appointed by Governor Arnold Schwarzenegger to advise the State of California on important public health matters. Second, California State Assembly members on the Committee on Agriculture are central stakeholders for instituting policy and are accountable for representing and protecting the interests of Californians. Lastly, the United Farm-workers Union is an instrumental player with strong local legitimacy for raising the public awareness of Californians regarding the rights and needs of farm-workers.

### ***Specification of migration stream and theoretical rationale***

Migration between California and Mexico pre-dates the annexation of California and its admission into the United States in 1850. As California's agricultural sector grew and immigration policies have changed over the passed century, migration dynamics have also changed. However, the motivating factors of this migration stream remain largely economic. The reasons for migration today are specifically large wage differentials between Mexico and the United States with greater work opportunities in the U.S. According to the neo-classical economic theory, through rational, cost-benefit analysis individuals will migrate if they project a positive net return from their investment: cost of travel, looking for work, safety concerns, etc. (Teitelbaum, 2008).

In addition to economic factors, social networks are key to the migration stream of farm-workers. The social capital theory affirms that, "eventually labor recruitment becomes superfluous, for once begun, immigration displays a strong tendency to continue through the growth and elaboration of migrant networks" (Massey, 2003). Finally, the dual labor theory serves as an overarching premise to explain the migration stream of farm-workers from Mexico to the United States. The dual labor theory asserts that "post industrial patterns yield a bifurcation of labor markets," where natives dominate the primary sector jobs (Castles and Miller, 2003). Secondary sector jobs are characterized by episodic or seasonal work, low pay, demanding physical labor often under harsh working conditions, and few opportunities for advancement; natives generally reject these jobs, creating a consistent demand for migrants.

Migrant farm-workers are vital to California's \$2.8 billion agricultural industry (USDA, 2006). They take the jobs that Californians do not want to perform, jobs that make California's agricultural economy the wealthiest in the United States (CEO Task Force, 2001). The number of seasonal and migrant farm-workers in California is not precisely known, but estimates range from 732,745 to 1,302,150 (Larson, 2000). They represent approximately 30% of the 3 million migrant and seasonal farm-workers working throughout the United States. Without their contribution current levels of agricultural production would not be possible; California's crops are labor-intensive, making production dependent on the availability of migrant farm-workers (CEO Task Force, 2001). Migrant farm-workers make a significant economic contribution in California and must be afforded basic human rights that include health care access.

### ***Who are migrant farm-workers?***

California's migrant farm-workers are predominately foreign-born, Latino, non-U.S. citizens, both documented and undocumented. Therefore, while other demographics (including diversity within the Latino migrant population) are recognized, the policies reviewed and suggested herein will be in reference to the predominate characteristics of this population. According to the National Agricultural Workers Survey of 2000 (Rosenbaum, 2005), 87% of migrant farm-workers speak little or no English, 90% read little or no English, and the median level of education is the 6<sup>th</sup> grade. These communication barriers are a major limitation to health care access. Median, annual per capita income is \$6,250, which explains why 59% of migrant farm-workers are living below the federal poverty level<sup>1</sup>. There is also a huge disparity in percentage of migrant and seasonal farm-workers without health insurance (85%) compared to low-income nationals (37%). This has a huge impact on families, since 66% of migrant farm-workers migrate with their families. Lastly, migrant farm-workers are more at risk for injuries and illness because of the nature of their work and living arrangements (Rosenbaum, 2005).

## **II. Statement of the Problem**

### ***Deteriorating health status and public health concerns***

As a result of the difficult challenges of getting into the U.S., migrants are positively selected for being healthy when they arrive in the United States. However, as a result of the nature of their work, their vulnerable social status, assimilation complexities, and inaccessible health care services, migrants health worsens the longer they are in the U.S. (Derose, 2007). Providing accessible health care is necessary to address migrant farm-workers deteriorating health status and to address public health concerns.

Migrant farm-workers health status as compared with the larger U.S. population is poor. In a survey of 971 farm-workers, men were four times more likely to suffer from iron deficiency anemia than men in the general U.S. population. In the same study, one third of men had at least one decaying tooth and 4/10 of the women had at least one broken or missing tooth; half of all

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<sup>1</sup> The federal poverty level is \$20,650 for a family of four (Poverty Level Guidelines, 2007). The federal poverty level and does not take into account the cost of living in California, which is estimated to be over \$50,000 a year (Hollyfield, 2007).

the men and 2/5 all the women had never been to a dentist (CEO Task Force, 2001). Migrant farm-workers are more at-risk for chronic, preventable diseases, such as diabetes and obesity. One-fifth of men in the CEO Task Force survey had two of three risk factors for chronic diseases (CEO Task Force, 2001). The effect of poor access to preventative health measures is significant. Access to preventive health measures reduces health problem escalation and reduces the need for emergency services.

Two main public health concerns with regard to the health of migrant farm-workers include: addressing insufficient prenatal care and addressing the spread of tuberculosis. Maternal and newborn health is at serious risk under the current system. Without easy access to care, many women do not receive sufficient prenatal care, therefore resulting in increased premature births, complicated births, and high costs to tax payers.

The spread of tuberculosis and other infectious diseases are significant public health concerns where improved health care access for migrant farm-workers could make a big difference. Tuberculosis is 8.7 times more prevalent in foreign-born populations than U.S. born (CDC, 2004). Although the U.S. as a whole has seen a decline in the number of TB cases, California, Texas, and New York (states holding the largest percentages of migrant farm-workers) represent 42.4% of the new cases and all showed an increase in their numbers of TB cases for 2003 (CDC, 2004). Tuberculosis is especially worrisome with regard to migrant farm-workers because they are more likely to have been exposed to TB in their home country and not treated, therefore becoming latent TB carriers. If undetected in the U.S. and left untreated, TB can become active due to illness or a weakened immune system. Farm-workers are also more susceptible to contracting TB from fellow migrant workers because of living in close quarters and because of malnutrition. However, if latent TB is screened for and detected, it is easily treated and can prevent the emergence of active TB for that individual as well as eliminate the risk of spreading TB to the larger population.

### ***What are the contributing factors to migrant farm-workers poor access to health care?***

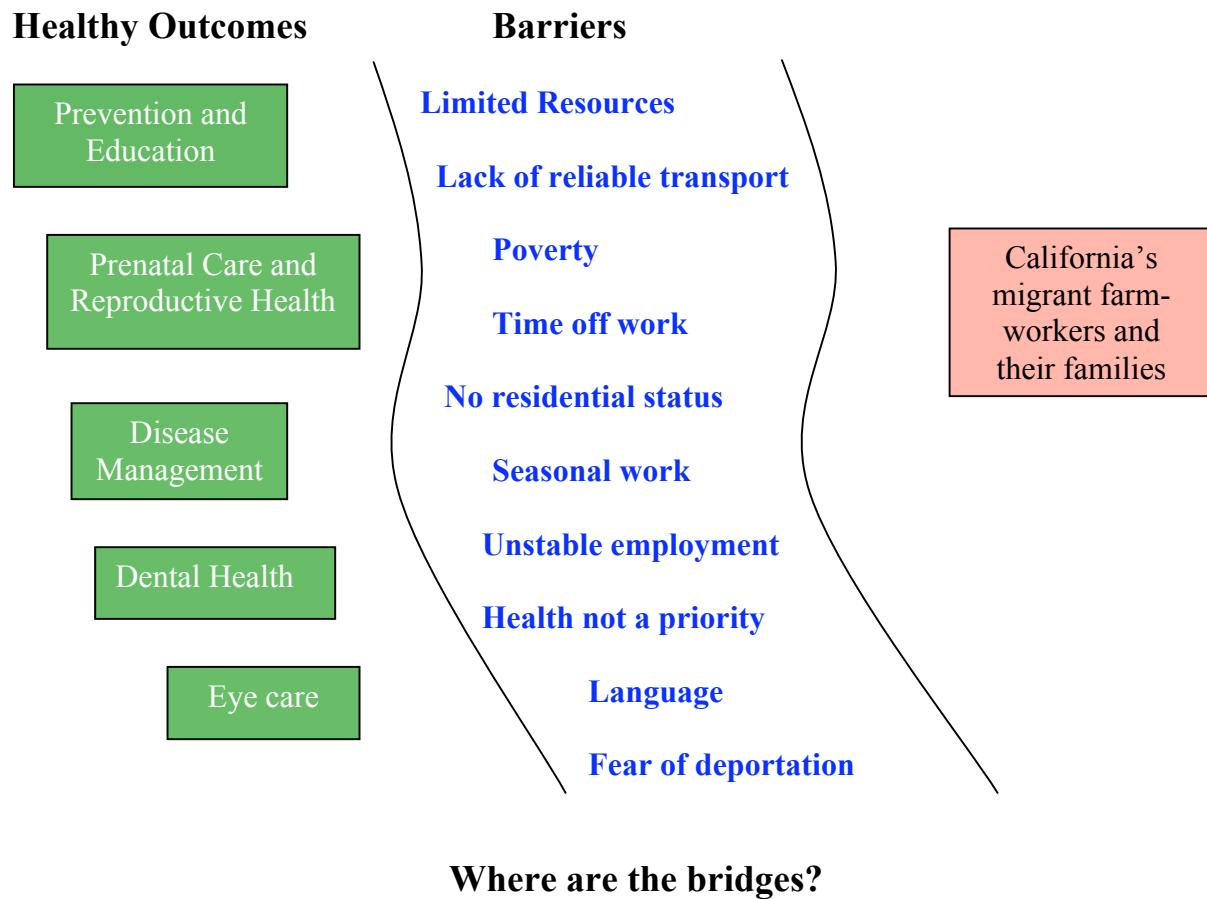
There are both structural and social variables that determine migrant farm-workers lack of access to health care. Structural limitations include limited access to resources, such as lack of transport and low wages or unstable employment, all of which can contribute to poverty. These reasons inhibit migrant farm-workers from going to the clinic because they can neither

afford to take the time off from work, nor is there reliable or efficient transport to get there. Another structural limitation is the impermanence of their residence, which denies them eligibility for some benefits. Migrants often move between states and counties to follow the harvest season. State and county policy vary and can complicate migrants' eligibility for care. An overarching structural limitation is employment instability, which creates insecurity and does not allow for prioritizing health care. Lastly, the structure of immigration laws and government regulation for health care eligibility means that some migrant farm-workers are not eligible for health care due to their immigration status.

Social limitations are the other main determinants why migrant farm-workers don't have adequate access health care. The main social limitation is language (Derose, 2007). Language barriers limit knowledge of eligibility, cause apprehension of social interaction in the health care setting, and lead to decreased use of health care facilities. Another main social limitation for undocumented farm-workers is fear of their status being discovered and possible deportation. This fear can cause decreased use of health care facilities. Decreased use of health care facilities minimizes the potential for having a "usual source of care [which] is important for continuity of care" (Wallace, Gutierrez, and Brown, 2003). Finally, migrant farm-workers who do attempt to access health services often face discrimination regardless of their immigration status.

### ***Independent and Dependent Variables***

The dependent variable for this policy memo is improving health care access for migrant farm-workers in California. The independent variables include the methods for achieving better health care access.



### III. Policy Alternatives and Analysis

#### *Criteria*

The following criteria are used to assess the alternatives identified as possible solutions to improve health access for migrant farm-workers in California.

- Effectiveness: Does the policy alternative address the structural and social factors that are root causes of poor health access?
- Political Acceptability: Will the policy alternative receive political support?
- Cost Effectiveness: What is the cost of implementing the alternative?
- Level of Coverage: What percentage of the target population will have improved health access as a result of the alternative proposed?

### ***Option 1: Expand public insurance for health care***

Expanding public health care insurance coverage is an umbrella option that could involve providing insurance to all children regardless of immigration status and decreasing the limitations for Medi-cal and Healthy Families to allow coverage of non-parent adults under a specified poverty level (Rosenbaum, 2005). Since this option is based on using the same standardized methods of care, the effectiveness of this option to address problems of structural or social access is very low. Expanding public insurance for health care is a highly debated topic, so with regard to political acceptability, expanding health care to some degree would receive sufficient support to make it a viable option. There are significant political actors, including Governor Schwarzenegger, who have created acceptability in the political arena to prioritize the expansion of public insurance. The cost effectiveness of this option is difficult to measure because although the costs of expanding primary care and preventative health coverage would be high, the money saved to the state from emergency-based interventions would compensate for some (or all) of the health insurance costs. An example of this is prenatal care, where every dollar spent is estimated to save \$3.38 in potential costs for the care of infants with low birth-weight (Henderson, 1994). This option would provide a medium level of coverage because all children of migrant farm-workers could receive health care insurance coverage and there is the potential for non-parent adults under a specified poverty level to be insured. However, undocumented adult immigrants would not be covered. Because the percentage of undocumented migrant farm-workers ranges from 15-50%, the extent of the impact of this option is not clear.

### ***Option 2: Mandating employers to provide health insurance or subsidizing employer-based health insurance***

The second option is creating a policy for mandating or subsidizing employers to provide health insurance. This option would entail an oversight agency to track employers and ensure that they provide health insurance to the migrant farm-workers that they employ. The other side of the option is to work toward a collaborative health insurance policy between the government and agricultural employers to subsidize the provision of health insurance to migrant farm-workers. The effectiveness of this policy in addressing social and structural limitations to access is very low. Employer provided health insurance would not guarantee a decrease in any of the

social or structural limitations. In addition, the nature of seasonal farm-work means that farm-workers often change employers throughout the year, making it very difficult to track. The political acceptability of mandating employer provision of health insurance is very low because of the political power of the agricultural industry and their low prioritization in paying for farm-workers health. In addition, the enforcement of employer-given insurance may be difficult to track or may encourage employers to hire more undocumented migrants to avoid paying health care. Employer involvement in the provision of health care would be a positive asset to address the financial challenges to providing care because the owner's revenue from production is a direct result of migrant farm-workers. Therefore they would be held accountable for paying a fuller cost of production. Lastly, with regard to the level of health insurance coverage, employer-enforced insurance would be low because it would only provide insurance to documented migrants since it would be tracked through the government.

### ***Option 3: Increase community health outreach***

Community health outreach involves initiatives to provide health access and services to clients where they live and work rather than standardized methods of access in clinics or hospitals (CEO Task Force). Two key types of community outreach are mobile health clinics and *promotoras* (community health advocates). Mobile health clinics are vehicles that provide health care services. *Promotoras* are community health advocates and leaders who work from an insider perspective to identify local resources, facilitate health discussions, and create strategic partnerships to make change in their communities (Andrews, 2007). Currently community health outreach is a very low priority for funding and is only being used by special interest groups in the health field, such as for TB screening or dentistry. This option asserts that community health outreach should be increased to become the central strategy for providing migrant farm-workers with health care access.

Outreach efforts inherently address structural limitations of health care access because the services meet the client where they are as opposed to fostering expectations for the client to go to the location of the services. Outreach efforts also often use nontraditional timing, such as ensuring that visits are made on non-work days. Outreach efforts are tailored towards the needs of a particular client population (in this case migrant farm-workers). Therefore, community health outreach addresses social limitations by providing culturally and linguistically appropriate

services. Community health outreach initiatives are operated by nonprofit health care organizations and are most often funded through private and public grants or county and state funding. As a result, community health outreach efforts would be politically acceptable because each community and each project would be evaluated for appropriateness to that community. The financial costs of mobile clinics and *promotoras* outreach programs can be higher than more standardized methods of care because they target the most vulnerable clientele and provide specialized care. However, this population has proven not to use the services of standardized care and often delay seeking treatment until there is the need for emergency-level care - in which case costs may be justified based in comparison with high emergency room costs. Finally, the level of coverage would be very high because the objective of community health outreach is to provide nondiscriminatory coverage.

***Decision matrix***

The following decision matrix charts the policy options against the four criteria discussed to determine which policy provides for the best outcomes. Each option is rated through a system ranging from one to five stars (\*) to indicate the degree to which it satisfies the criteria. One star (\*) is the lowest rating and signifies that the policy option does not accomplish the desired outcome. Five stars (\*\*\*\*\*) indicate that the desired outcome is completely fulfilled by the policy option.

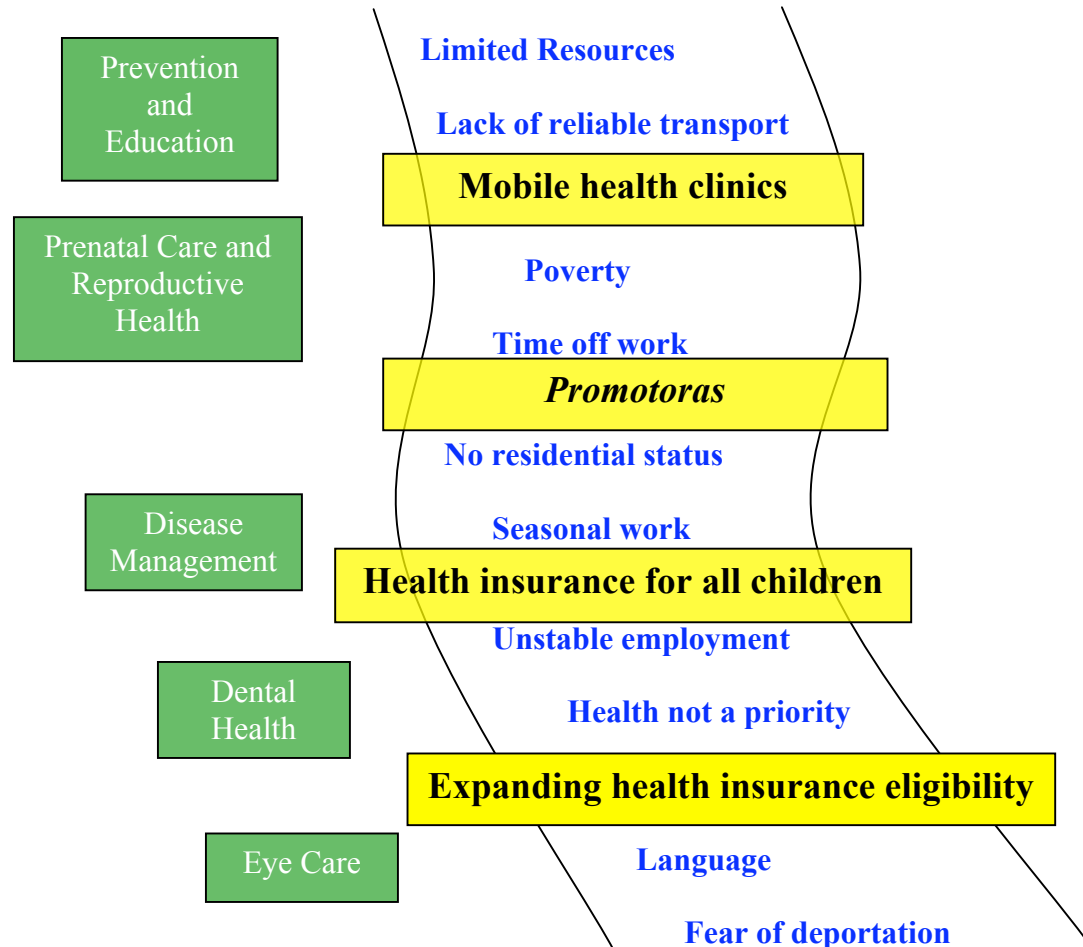
<b>Options/Criteria</b>	<b>Effectiveness</b>	<b>Political acceptability</b>	<b>Cost Effectiveness</b>	<b>Level of Coverage</b>	<b>Total</b>
(1) Expand public health insurance	**	****	***	***	12
(2) Mandate employers to provide health insurance or subsidize employer-based health insurance	*	*	****	**	8
(3) Increase community health outreach	*****	***	***	*****	16

#### **IV. Policy Recommendations**

After review of the policy options for increasing health care access for migrant farm-workers in California, I recommend a combination of the first and third options. In developing policy, a greater weight would be placed on increasing community outreach while some expansion of public health insurance would be included. Through examination of the options in relation to the identified criteria, community outreach received the highest total in the decision matrix. In particular, community outreach measures have demonstrated the best outcomes for addressing social and structural limitations to health care access and outreach presents the highest level of coverage, allowing for nondiscriminatory access to migrant farm-workers. Mobile health clinics and *promotoras* programs have progressed community outreach efforts substantially through culturally and linguistically appropriate services. Community outreach, in particular, allows for a linkage to more standardized methods of care, such as clinics and hospitals. Therefore it could serve to enhance the use of existing services.

The weaknesses of the community outreach measures are political acceptability and cost, which are rated as viable, but not high. Therefore, matching community outreach with public health care expansion can provide greater political backing for the measures and provide necessary funding.

## Healthy Outcomes



### *Limitations*

A central limitation of the recommended solution is related to having a broad dependent variable. Improving health care access is very broad and difficult to evaluate. In addition to clinic care for acute illnesses like injuries, infections, and hospital care for life-threatening diseases, improving health access should include important preventative measures such as immunizations, provision of birth control, health education, and screening for TB and STIs. This limitation is inherent in the health care field because it is more difficult to measure whether someone's health outcomes were impacted by greater health prevention or health education methods. Clear outcomes are mainly related to addressing and managing existing health problems where a change can be readily documented. However, preventative measures may have a greater impact on individuals' overall health in the long term.

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Appendix A  
Stakeholder Analysis

Stakeholders	Interest in the issue / what is at stake
<b>Primary Stakeholders</b>	
Migrant workers and families	-Health, safety, dignity
Hospitals (ER), community clinics	Workload capacity, language capabilities, processing insurance forms, compensation for services
U.S. citizens	Services at ER affected, public health (especially control of infectious diseases, affect on taxes
Agricultural Industry Owners	-Profits -Reputation -Coordination -Providing time-off for health checks
CA Department of Public Health Federal DPH County level public health	-Safety of citizens and all individuals -Preventing public health crises -Health care costs- current and future
<b>Secondary Stakeholders</b>	
Migrant workers education programs	-Health education
Labor rights organizations	-Workers health care rights
<b>Minor Stakeholders</b>	
INS and border patrol	-Application of migration policy and procedures
Agricultural labor contractors	-Hiring migrant workers
Mexican government	-Political relations
US Department of Agriculture	-Food safety

**Table of Importance and Influence**

The table below lists all stakeholders and ranks their level of importance and influence on the current issue. The level of influence demonstrates the amount of power the stakeholder has in changing the current situation.

Stakeholders	Level of importance of the issue	Level of influence on current situation
Migrant workers and families	3	1
Hospitals and community clinics	4	3
U.S. citizens	3	1
Agricultural industry owners	1	5
Federal DPH	2	4
CA DPH	4	3
County DPH	4	3
INS and border patrol	1	2
Agricultural labor contractors	1	2
Migrant workers' education programs	5	2
Labor rights organizations	5	3
US Department of Agriculture	2	4
Mexican government	1	1

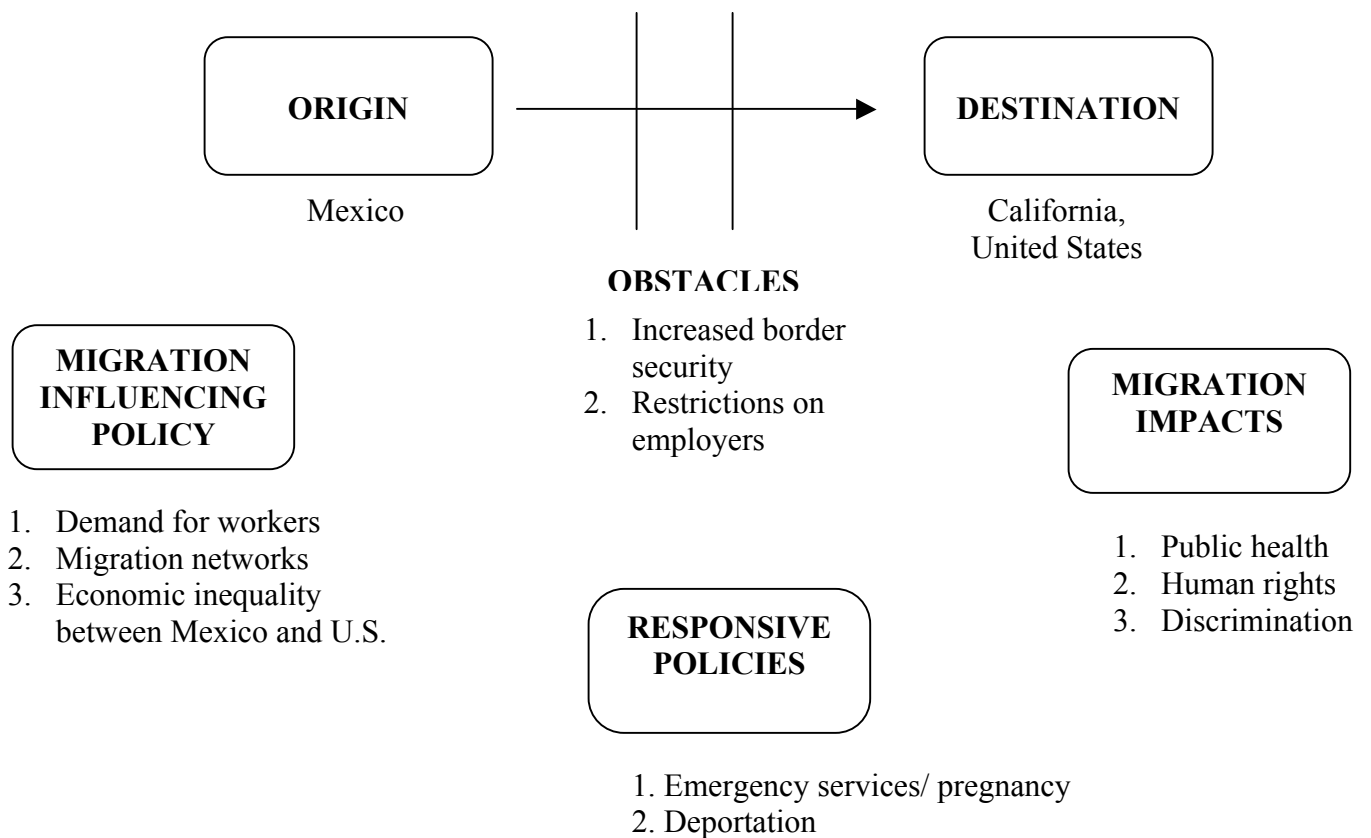
(5=highest level of importance/influence, 0=lowest)

## Importance/Influence Matrix

This matrix plots the importance/influence of each stakeholder into quadrants.

High Importance/ Low Influence	High Importance/ High Influence
<b>A.</b> Migrant workers and families Migrants rights NGOs in CA U.S. citizens	<b>B.</b> CA DPH Hospitals and community clinics Labor rights County DPH
<b>C.</b> Mexican government INS and border patrol Labor contractors Federal DPH	<b>D.</b> Agricultural industry owners
Low Importance/ Low Influence	Low Importance/ High Influence

## MIGRATION FLOW CHART



## Appendix B

### Current Safety Net Health Care programs

Program	Eligibility	Targeted population	Coverage	Cost to individual
Medi-Cal (Medicaid)	Infants $\geq$ 1yr. with family income up to 200% FPL; 1-5yrs at 133% FPL; 6-19yrs at 100% FPL Preg. Women up to 200% FPL and parents up to 100% FPL	Mostly children and select adults below FPL	Children- full medical and limited dental and vision; Pregnant women- prenatal care only	Minimal
Emergency Medi-Cal	Similar poverty requirements to regular MediCal	Undocumented immigrants and other immigrants who don't meet regular MediCal requirements	Prenatal care, long-term care	Minimal
Healthy Families	Family income at or below 250% federal poverty level	Children under 19 years who are not covered by Medi-Cal	Health, dental, vision	Monthly premium \$4-15/child Max \$45 for all children
SCHIP	Family income less than \$36,200 (for family of 4) Immigrants must wait 5 years to be eligible	Children under 19 years who do not have Medi-Cal	Doctors visits, immunizations, hospitalizations, ER visits	
<i>Promotoras</i>	Spanish-speaking; immigrants	Uninsured Latino population	Assist with access, overcoming linguistic and cultural barriers, and help with identifying resources	Still responsible for health care costs, but could be sliding scale
Community health care centers	Some coverage provided through Medi-cal and county medical service indigent funds via poverty requirements	Low-income citizens and immigrants	Primary care	Nothing if eligible for MediCal; sliding scale based on income if indigent

Planned Parenthood Family/ PACT		Low-income public	Reproductive health	
Mobile health clinics	Some coverage provided through Medi-cal; poverty requirements	Underserved, vulnerable populations	Primary care, Dental, Reproductive health, immunizations, etc.	Similar to community health care center above

## Afterword

I was initially drawn to this topic and considered it an opportunity to learn more about U.S. public health insurance programs and how they provide (or do not provide) for vulnerable populations in California. I was specifically interested in looking at creative ways to reach migrant farm-workers, since they are such an integral part of the community in this region of California. From my work both as an HIV educator in Swaziland, and as a social worker with the homeless population in San Francisco, I have learned the importance of *reaching out* to a target population rather than simply expressing passive concern. I feel that this is particularly important with regard to health care services because it is a basic human need and right that is often neglected. In Swaziland I saw the success of mobile HIV testing units - as I researched migrant farm-workers I became instantly intrigued with the small amount of literature on mobile health clinics.

A recurring frustration while preparing this policy memo was my lack of connection to the fieldwork that would have enabled a richer understanding of the issues. I made attempts at contacting practitioners and then held off on continued communication because of the required need for university-approved contact with human subjects. This paper is therefore solely based on literature-reviewed research, and while I feel it is comprehensive, it none-the-less could have benefited from the inclusion of first-hand interviews. Attached is a list of potential contact organizations (individuals were identified during my inquiries but are not included in this list) for further research. Furthermore, as my research concluded I found evidence that many of my proposed outreach suggestions (*promotoras* and mobile clinics) are in action to some degree. Therefore, further research to evaluate the effectiveness of these efforts could be warranted. I could not find evidence of an evaluation of community outreach efforts. Additionally, I believe there are other areas needing further research, and I list these below.

### Further research areas:

- Statistics (current statistics were hard to find, the following statistics would be particularly important to establish in further research)
  - How many migrant farm-workers are using the public insurance programs described in Appendix B?
  - Cost savings of reducing the use of emergency services through greater preventative measures

- How much migrant farm-workers contribute into the system in the form of taxes, etc. as compared with how much they use public assistance?
- Statistics backing the need for greater maternal and newborn health
- Evaluation of the effectiveness of community outreach efforts- *promotoras* and mobile clinics
- Discussion of reproductive health needs particularly with regard to outreach program effectiveness on reducing unintended pregnancies.
- Models taken from international examples for creating health care access

Contacts Further research:

- Community Unity Oral Health, Salinas
- Yakima Valley Farmworkers Clinics, Salinas
- Center for Community Advocacy, Salinas
- Poder Popular, Salinas
- Catholic Charities, Salinas and Watsonville
- Planned Parenthood Mobile Health Care
- Mobile Health Clinics Network, Nationwide
- Monterey County Department of Public Health, Community Health
- Clinica de Salud, Mobile Medical and Dental Clinic
- Farmworkers Union, Watsonville
- Public Policy Institute of California, San Francisco
- California Immigrant Policy Collaborative
- Clinica Sierra Vista, Bakersfield
- Health Access for California, Sacramento