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Guestworkers:
The precarious future of farm work in the U.S.

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Immigration is once again in the headlines, and farm work is on the agenda in Washington. In the not too distant past the efforts of politicians and unions were aligned against immigration, fearing that native jobs were threatened. Now all the talk is about how to formalize the immigrant labor force and recruit more foreign workers. President Bush is in ongoing discussions with President Fox of Mexico; under consideration is the expansion of a temporary worker program that would allow Mexican workers to eventually gain permanent residency.[1] The United States already has a temporary worker program for agriculture. The number of temporary job certifications for agricultural work is growing rapidly and now exceeds 40,000 per year. Several proposals are moving through Congress would increase that number significantly, some to over 250,000 per year.[2]

What is a guestworker?

A guestworker is a foreign worker who enters the United States with a temporary visa. The guestworker program for farmworkers is called the H-2A temporary foreign agricultural worker program and is administered mainly by the U.S. Department of Labor. It is estimated that 42% of current guestworker certifications are for work in tobacco cultivation. Vegetable harvesting and apple harvesting come next, at 21% and 10% respectively. More than half of all H-2A certifications are in the Southeast. North Carolina leads the states with over 10,000 certifications, or over 25% of the total. Other states with more than 1,000 certifications include Georgia, Virginia, Kentucky, New York, Tennessee, Connecticut, Texas, Arkansas, Nevada, and South Carolina.[3]

Employers who claim labor shortages in their local area can apply to contract with foreign workers on a seasonal basis. In order to qualify for the program, employers are required to provide:

- Wages equivalent to those of similarly situated U.S. workers
- Housing for the workers which must be inspected by the Department of Labor
- Transportation from the housing to the place of work
- Facilities where workers can prepare food and meals
- Workers compensation insurance

None of these benefits are guaranteed to most migrant and seasonal farmworkers. In some ways the guestworker program presents an improvement on the work and living conditions which farmworkers typically face.

The dynamics of the guestworker program creates other problems for farmworkers. Guestworkers are contracted to work with a specific employer and they are dependent of the employer's good will. If there are problems with wages, if the work is unsafe, or if the employer-provided housing is inadequate or unsanitary, the farmworkers are reluctant to complain. Because guestworkers are not allowed to pursue a job with another employer, they are forced to decide between living with poor conditions or returning to their home country with little or no money to show for their efforts.

The guestworker program also impacts health care delivery. Guestworkers usually do not have a vehicle of their own and employers are not required to transport them to medical care (only in the case of certain emergencies, like a pesticide spill.) Guestworkers are also dependent on their employers for information about local health services. Health educators and outreach workers often find it difficult if not impossible to visit guestworkers if their housing is on the employer's property. The result is that guestworkers live in a very restricted environment where options for health care access are greatly reduced.

Agricultural employers want to change the H-2A visa program so that it will be more flexible and make it easier to hire workers quickly, avoiding what is perceived as bureaucratic red tape and burdensome regulations. Employers also want to expand the guestworker program in part because the INS is cracking down on undocumented workers, threatening the company or farm labor force during critical production times. It is estimated that over half of all farmworkers are unauthorized.[4] Unions and farmworker advocates argue that if growers paid more wages and provided more benefits there would be no labor shortage. They also view the H-2A system as containing protections for the workers that are unfulfilled and rarely enforced.

Last year a compromise on guestworker

1 "Bush welcomes Fox at White House", Main Page, CNN.com, Sept. 5, 2001.
2 "Mexican 'Guest Workers': A Project Worth a Try?", New York Times, April 3, 2001.
3 Ruth Ellen Wasem, Geoffrey K. Collver, "RL30852: Immigration of Agricultural Guest Workers: Policy, Trends, and Legislative Issues", Congressional Research Service Report for Congress, February 15, 2001.
4 U.S. Department of Labor, Findings from the National Agricultural Workers Survey 1997-1998, Research Report No. 8, March 2000.

continued on page 2

New Resources Available from MCN

MCN has recently published several new resources for clinicians.

Puntos de Vista: Primary Eye Care for Farmworkers and Their Families

This manual begins with an overview of primary eye care services a clinic may choose to implement (Chapter One), and a primer on basic eye anatomy and vision, including the signs and symptoms of common vision problems (Chapter Two).

Chapter Three details training on how to actually perform vision screenings and basic eye exams, including how to recognize eye problems and make accurate referrals. Chapter Four provides basic first aid as well as prevention education relating to common diseases seen within the migrant population.

Chapter Five addresses how to use the focometer for measuring refractive and astigmatic errors accurately. For sites that will be dispensing eye glasses, Chapter Six covers reading prescriptions and assembly of eyeglass kits.

Finally Chapter Seven specifically addresses taking primary eye care "to the field" by performing vision screening, eye exams, first aid, and prevention education in outreach settings such as migrant camps or homes.

For more information or to order a copy of this manual contact Stephanie Freedman at 512-327-2017 or *sfreedman@migrantclinician.org*.

Migrant Farmworkers and Diabetes: A Monograph

Monographs are one mechanism used by MCN to address gaps between medical care knowledge and migrant health practice. As the diabetes epidemic has become a public health crisis, MCN has provided leadership and resources to address this chronic disease condition in the migrant and seasonal farmworker community. This monograph describes MCN's efforts in diabetes care and the first systematic treatment of diabetes devoted to the farmworker community. It also describes efforts on the part of the Bureau of Primary Health Care to develop strategies through the Collaborative process to address diabetes. Finally, the monograph provides a series of clinical tools for use by those treating migrant patients.

For more information or to order a copy of this manual contact Stephanie

continued on page 4

Guestworkers: The precarious future of farm work in the U.S.

continued from page 1

legislation was reached between the National Council of Agricultural Employers, a growers' organization, and the United Farm Workers. The compromise proposed two changes. First, the current H-2A system would be streamlined and recruitment procedures would be reduced. At the same time, guest workers would for the first time receive some protections from the Migrant and Seasonal Agricultural Worker Protection Act (AWPA) including a right to file suit in federal court, work disclosure requirements, and transportation and housing standards. Second, a new "agricultural worker adjustment" program would be established that would allow guest workers to become "temporary resident aliens" with the ability to convert to permanent resident status after completing a work requirement.[5]

Although the compromise was a historic breakthrough for labor and management, Senator Phil Gramm, (R-TX), blocked the bill because of the legalization plan.[6] Senator Gramm supports a guestworker plan that is more similar to the Bracero program that existed until 1963. Over 4 million Mexican braceros worked in the United States between 1942 and 1963 with no chance of becoming permanent residents or citizens and with few labor protections.

After the compromise bill stalled, agricultural employers transferred support to legislation introduced by Senator Larry Craig, (R-ID). The Craig bill replaces paying guestworkers with the average state wage, often more than $7 an hour, with a "prevailing" wage, that may not be much more that the minimum wage. The Craig bill would also continue to exclude guestworkers from coverage under the Migrant and Seasonal Worker Protection Act (AWPA). The bill contains a provision that would allow farmworkers to apply for permanent residency if they work 150 days per year in each of four years during a six -year period, virtually excluding guestworkers who are in the United States only on a temporary or seasonal basis.

Most recently, Senator Ted Kennedy, (D-MA), and U.S. Representative Howard Berman, (D-CA), have proposed an alternative bill. The proposal also includes a route to apply for permanent residency but lowers the requirement to 90 days per year in 3 out of the last 4 years. The Kennedy-Berman bill, like the compromise bill, gives "temporary resident alien" status to guestworkers, allowing them to work with any employer they choose. Employer recruiting obligations would be eased. But the employers will still need to hire U.S. workers who are qualified and apply during the first half of the season. The bill allows employers to provide a housing allowance instead of actual housing and grants farmworkers the right to join or organize labor unions without retaliation.[7]

What can clinicians do?

- Become knowledgeable about guestworkers in your area, and how the H-2A system operates in your state.
- Talk with farmworkers about their experiences with the guestworker program.
- Speak at public forums about the health implications of guestworker proposals.
- Meet with policy-makers, employers, and advocates about potential reforms.

Note: This article draws heavily on the publications and reports of the Farmworker Justice Fund, Inc. Readers are encouraged to contact FJF or read their web site at www.fwjustice.org for updates and further information.

5 Bruce Goldstein, "The Potential Compromise on Immigration Policy and Agriculture", Farmworker Justice Fund, March 2001.

6 Robert Collier, "Call for U.S. reform riles immigrant foes", San Francisco Chronicle, March 21, 2001.

7 For a more detailed discussion of this bill, see Bruce Goldstein, "Sen. Edward Kennedy and Rep. Howard Berman Introduce Bills on Immigration/Legalization for Farmworkers", Farmworker Justice Fund, Summary S1313 available at www.fwjustice.org.

The Health Promotion and Disease Prevention Agenda of the U.S.-Mexico Border Health Commission

The Healthy Border 2010 Program is the U.S.-Mexico Border Health Commission's Health Promotion and Disease Prevention Agenda for the U.S.-Mexico Border region designed to facilitate and support community-based solutions. It is a statement of regional health objectives to identify some of the most significant preventable threats to health and establish goals to reduce those threats in the ten U.S. and Mexican Border States.

Healthy Border 2010 is composed of the common elements from two national programs, the Mexican National Health Indicators Program, and the U.S. Healthy *Gente* Program. Out of the 46 Mexican health indicators and the 25 U.S. Healthy *Gente* objectives, there are 19 common measures. The objectives represent most of the priority areas for action on health issues in the border region. The selection of these common elements will help to focus health improvement activities on both sides of the border, guiding the allocation of health resources and the development of binational health projects. Health problems considered each country would address priority issues on only one side of the border separately.

Because of differences in the organization of the health care systems in each country, as well as other differences, the Healthy Border 2010 Program does not attempt to impose identical objectives on both sides of the border. Rather, the program identifies topic areas that are approximately the same in the border regions of both countries. The specific objectives, as well as the targets for the year 2010, are defined by each country and differ to at least some extent for most objectives.

Implementation of Healthy Border activities will also differ in each country. The goal will be the development of appropriate activities to address health issues, with the organization of these activities dependent on local circumstances, including the structure of the health care system, available resources, and other issues. These activities should bring in as many partners as practical, including international organizations, non-governmental organizations, and the private sector. Binational activities, especially those established in sister cities along the border, should be developed through the existing cooperative infrastructure.

Healthy Border 2010 Program Objectives

The 19 common elements included in the Healthy Border Program are grouped into 11 topic areas. The topics with specific areas of focus are as follows:

1) **Access to Health Care**
   - Access to primary care/basic health services
2) **Cancer**
   - Breast cancer mortality
   - Cervical cancer mortality
3) **Diabetes**
   - Diabetes mortality and hospitalization
4) **Environmental Health**
   - Household access to sewage disposal
   - Hospital admissions for acute pesticide poisoning
5) **HIV/AIDS**
   - HIV/AIDS incidence
6) **Immunization and Infectious Diseases**
   - Immunization coverage for young children
   - Hepatitis incidence
   - Tuberculosis incidence
7) **Injury Prevention**
   - Motor vehicle crash mortality
   - Childhood unintentional injury mortality
8) **Maternal, Infant and Child Health**
   - Infant mortality
   - Infant mortality due to congenital anomalies
   - Prenatal care
   - Teenage pregnancy rate
9) **Mental Health**
   - Suicide mortality
10) **Oral Health**
   - Access to oral health care
11) **Respiratory Diseases**
   - Asthma hospitalization

Each of these indicators will be matched with specific quantifiable goals such as to reduce the proportion of residents lacking access to a primary provider in underserved areas by 25 percent or to reduce the female breast cancer death rate by 20 percent.

For the first decade of the 21st century, the USMBHC will track these indicators and, through Healthy border 2010, help communities to implement programs to improve the health of border residents.

These topic areas focus on specific issues that greatly affect the health of individuals and communities in the border region. Monitoring progress in these areas will highlight achievements and challenges in border health during the next decade.

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continued from page 2

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Addressing Domestic Violence in a Clinical Setting

It has been more than twenty years since the first large-scale effort began to confront the issue of domestic violence. During this time, in an effort to demonstrate that no woman is immune to violence, there has been an attempt to minimize the differences amongst woman experiencing violence. We are now beginning to understand that despite the fact that any woman can be subject to intimate partner violence, their life situations can vary considerably. In order to effectively address domestic violence in diverse populations, it is important to recognize the impact of distinctive social, cultural, and economic circumstances.

Migrant and immigrant women are one group with a set of unique challenges. In general, these women face increased barriers to prevention and intervention services, which can magnify the affects of intimate partner violence. Due to the distinctive life style of migrant farmworkers, the stress of travel, low income and language barriers can be potential factors for abuse. Lacking access to health services, fearing deportation, and living in isolated environments, farmworker women are often forced to endure the violence rather than finding a means to escape.

This manual is designed for **health care providers** working with migrant and immigrant woman. While the manual stresses the importance of screening and documentation for all patients, it also addresses issues unique to migrant and immigrant women.

Chapter One provides a general overview of the migrant population as well as a section, which addresses the responsibilities of migrant health providers.

Chapter Two provides a general overview of important characteristics of family and intimate partner domestic violence with an emphasis on migrant and immigrant battered women.

Chapter Three provides a practical screening guideline for use in a health care setting.

Chapter Four addresses the development and implementation of safety plans.

Chapter Five deals with the important topic of documenting evidence when you see a case of abuse.

Chapter Six outlines legal remedies for domestic violence, particularly in an immigrant community.

For more information or to order a copy of this manual contact Stephanie Freedman at 512-327-2017 or *sfreedman@migrantclinician.org*.

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