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PARALLEL SYSTEMS OF HEALTH CARE:  
HOW GRASSROOTS ORGANIZATIONS AND HEALTH CARE  
PRACTITIONERS PERCEIVE FARMWORKER HEALTH

by

ANDREA OCASIO CRUZ

A thesis submitted in partial fulfillment of the requirements  
for the Honors Undergraduate Thesis Program in Anthropology  
in the College of the Sciences  
and in the Burnett Honors College  
at the University of Central Florida  
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Thesis Chair: Reyes-Foster, Beatriz

## Abstract

Socioeconomic and citizenship barriers prevent farmworkers from accessing public health care; thus, grassroots organization members and health care practitioners collaborate to create community health clinics that provide care for farmworkers and low-wage immigrant workers. Such community clinics are known as parallel health care systems, yet the concept's existing literature lacks comprehensive studies on the parallel systems operating within farmworker communities. To fill this research gap, I conducted nine semi-structured interviews to collect the perceptions of key community stakeholders involved in providing accessible health and financial aid to farmworker communities in Florida. I analyzed the interviews through the qualitative grounded theory method to identify which factors participants perceived as determining farmworker health outcomes, their explanations for why parallel medical systems emerge, and the differences and similarities between their answers. I found that the participants understood large-scale social structures to be influencing farmworker health outcomes. Furthermore, the participants described parallel health care systems as bridging structural gaps caused by the government's social abandonment of farmworker communities and health inequality. While the participants all similarly employed a structural framework to discuss farmworker issues, differences in perception arose during conversations of farmworker agency, the ambiguity of a "two-tiered health care," and proposed solutions. This study's findings contribute to the existing literature's observations on parallel health care systems, elaborate on the government's negative treatment of farmworkers during the COVID-19 pandemic, and generally highlight the voices of key community stakeholders currently working with farmworker communities.

## Acknowledgments

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## Introduction

Social marginalization, punitive immigration policies, and a lack of federal labor protections directly or indirectly obstruct farmworkers from receiving primary health care within the United States of America (Jezewski 1990, 499). In response to farmworkers' needs, grassroots organizations collaborate with volunteer health care practitioners to create pathways to health care that are accessible and affordable. Thus, contemporary understandings of farmworker issues are continuously emerging as local communities' interactions with farmworker populations increase through volunteer-driven health clinics' participation. This study collected and analyzed the perceptions of farmworker health emerging from such collaborations between grassroots organizations and health care practitioners in Florida. I also explored how participants embody the concept of volunteer-driven free health care, or parallel health care systems, by discussing the concept with them and connecting their interpretations to the existing literature (Castañeda 2010).

My reviews of the relevant literature helped narrow down the study's research questions, which ask: What explanatory factors do community stakeholders employ to explain their perceptions of farmworker health? What similarities and differences are identified within the distinct group's perceptions? Finally, how do the community stakeholders perceive parallel health care systems? Overall, I argue that this particular network of community stakeholders perceives farmworker health through a structural framework, connecting farmworker health outcomes to multiple social determinants of health, which, in turn, are shaped by large-scale social structures.

Although the participants all similarly used the structural framework to explain health outcomes, some expressed diverging perceptions. For example, I identified a contrast between



some participants' heightened concern with labels' victimizing effects on farmworker communities and other participants' practical applications of labels to explain structural inequality. Furthermore, I explored the variety of solutions proposed by the participants to reform harmful structural systems; I focused on how they positioned farmworkers within such solutions. Finally, participants perceived parallel health care systems as necessary to fulfill farmworker needs, left unattended by the United States' government. With that said, parallel health care systems were not perceived as reasonable solutions by this participant network; instead, many shared their ideal solutions for structural reform.

My interest in studying farmworker health from community stakeholders' perspectives began after volunteering at a free health care clinic hosted by the Farmworker Association of Florida (FWAF) in February 2019. As a volunteer, I witnessed the FWAF and the health care practitioners' combined work as they transformed the organization's office space into a temporary clinic for farmworkers and community members alike. Hopefully, this study's analysis yields valuable information for the community stakeholders interacting with farmworker populations in Central Florida. The following thesis chapters will present the literature review, methods, and results of the study, finalizing with a discussion and the possible conclusions derived from the study's analysis.

To contextualize the study's analysis of farmworker health perceptions and parallel health care systems, Chapter 2 reviews the relevant literature, such as medical anthropology's focus on health narratives, im/migrant health frameworks, farmworker health outcomes, and parallel health care systems. In particular, Castañeda et al.'s (2015) primary migrant health frameworks aided me in characterizing the community stakeholders' perceptions; equally, Biehl's (2005) social abandonment theory and De León's (2015) application of states of exception helped frame

the analysis within a macro-social frame. Chapter 3 then details the methods I used to collect and analyze the study's qualitative dataset. Semi-structured interviews yielded the study's key results, which I discuss in Chapter 4 and Chapter 5. Finally, Chapter 6 will report on the conclusions derived from the study's analysis to finalize this thesis.

As shown above, this study focuses on farmworker health through the perspectives of grassroots organization staff and health care practitioners localized in Central and South Florida. This study's conclusions serve to expand anthropology's general knowledge on community organizations' role within two-tiered medical systems, with an added insight into the emerging perceptions of the community stakeholders actively forming said conceptual medical system. Furthermore, considering that many farmworker populations depend on local organizations for health care, the public health field can gain current information on the newly emerging perceptions, methods, and strategies of local organizations providing care. Finally, the study may yield important information for the community stakeholders. I explore how the network understands sources for poor health outcomes, present conversations of victimizing and deservingness, and compare the proposed solutions to uncover core differences in their ideas.

## Chapter 2: Literature Review

The topic of farmworker health, and how community stakeholders perceive and care for it, is at this study's core. Therefore, this literature review focuses on presenting multiple scholars' findings on farmworker communities' health status, limited access to health care, and current forms of farmworker health care delivery. At the periphery of these core topics are my reviews of medical anthropology's conceptualization of health as influenced by large-scale social factors and immigration health studies' theories on the embodiment of immigration status. The aforementioned topics provided this study's theoretical foundations and aided me in linking participants' answers to macro-level structures, such as the United States' immigration policies and inaccessible health care system. The final topic reviewed in this chapter is the concept of parallel and two-tiered health care system. In this case, I adapted multiple scholars' perspectives on the topic to demonstrate the type of parallel health care embodied by this study's specific participant network.

### *Medical Anthropology*

Medical anthropology is the sub-branch of anthropology that focuses on the human experience of health and disease (Bhasin 2007, 1; Joralemon 2017, 8). This particular field encompasses research on ethnomedicine, the causes of illness, how people explain their illness and disease, and the development of medical knowledge systems (Bhasin 2007, 1). As I conducted my analysis, medical anthropology proved to have the necessary theoretical tools to understand and interpret community stakeholders' perceptions of farmworker health. That is to say, the medical anthropology field is specifically attuned to studying health through people's subjective views of health and illness; for instance, two critical medical anthropology approaches are illness narratives and phenomenology. The illness narrative approach focuses on how people

organize, process, and explain their illness experiences, while the phenomenological approach similarly studies "things as they appear in our lived experiences" (Desjarlais and Throop 2011, 88; as cited in Witeska-Młynarczyk 2012, 499).

Anthropologists who collect individual experiences and perceptions of health link their data sets to larger social structures; this is usually done to understand how local and global power relations shape individual experiences (Witeska-Młynarczyk 2012, 500). Critical medical anthropology, however, focuses primarily on such power relations. This particular sub-field further emphasizes the role that political power dynamics play in manifesting health inequalities, specifically probing at the larger structures shaping people's health experiences (Witeska-Młynarczyk 2012, 500). While the critical medical anthropology field asserts that macro-level (political and economic) forces are necessary to understand health outcomes, micro-level (people's lifeways, world views, and motivations) forces are not to be ignored; indeed, critical medical anthropology equally asserts the importance of "close-up examinations of local populations" to fully understand particular health issues (Singer 1986, 128)

The "social determinants of health" approach is not unique to medical anthropology, as the approach is prevalent in general public health studies (Braveman and Gottlieb 2014). However, considering medical anthropology's interest in bridging macro-level social structures to their corresponding micro-level health outcomes, anthropologists use the social determinants approach to understand how upstream social factors reproduce health outcomes (Castañeda et al. 2015, 376). The social determinants of health are composed of, but not limited to, "Educational and employment opportunities, economic stability, neighborhood context and housing, community norms, food security, access to information and resources, and policies" (as cited in Ramos 2017, 36). Such determinants can either protect individuals from or expose them to poor

health outcomes. The latter outcome can also refer to structural violence, which refers to the social structures or social determinants that impair individuals to entire populations from protecting themselves from harm (Castañeda et al. 2015; Farmer et al. 2006).

Structural violence often manifests into disease, especially within populations living in poverty (as cited in Farmer et al. 2006). Within the scope of medical anthropology, structural violence may take the form of preventable morbidity and mortality, such as the high rates of maternal and infant mortality within Latin American indigenous regions (Gamlin and Holmes 2018, 7). Even though health care physicians are growing their awareness of the "biosocial understanding of medical phenomena," it remains difficult to integrate the social determinants of health and the structural violence concept into the United States' health care system (Farmer et al. 2006).

#### *Im/Migrant Health Studies*

The term im/migrant is a combination of the terms "migrant" and "immigrant"; scholars use the term to acknowledge the overlapping meanings that populations may inscribe onto the terms. For instance, the multiple processes of leaving, arriving, and the periodic or permanent trajectory of a person to a place are underscored by combining both terms, emigrating and immigrating (Castañeda 2010, 7). Within the field of im/migrant health studies, the concept of "illegality" and how it impacts people's bodies, identities, and health care access, is a focal topic. So much so that anthropologists set aside their usual focus on culture to prioritize the "broader structural determinants of health" that tremendously influence immigrant health (Castañeda 2010, 6; Chavez 2003, 197). However, that is not to say that cultural frameworks are not abundant in im/migrant health studies.

Although scholars continue to push the field toward embracing a structural framework, the public health literature on im/migrant health still primarily revolves around immigrants' behaviors and presumes that immigrants' cultures are a primary determinant of health (Barry and Mizrahi 2005; Garcés, Scarinci, and Harrison 2006; Hennessy-Burt et al. 2011). In stark contrast to the cultural and behavioral frameworks prevalent within im/migrant health studies, the structural framework "interprets health outcomes through understanding and accounting for the large-scale social forces that impact health" (Castañeda et al. 2015, 381). Like the social determinants of health approach, the structural framework focuses on how social, economic, and political factors external to one's bodies actually shape health outcomes (Castañeda et al. 2015, 381). Castañeda et al.'s (2015) delineations of behavioral, cultural, and structural frameworks within im/migrant health studies helped me characterize the study participant's perceptions by following the focuses of each framework and comparing them to each participants' interviews.

Medical anthropologists and public health scholars have further developed the social determinant approach by arguing for immigration as a social determinant. According to Castañeda et al. (2015), embodying an immigrant identity contains people's behaviors and affects social positioning; dismissing the connection between immigrant identity and health outcomes overlooks how specific adverse health outcomes are explicitly caused by anti-immigration policies (376-378). An example of the effect that immigration has on social positions is the concept of health deservingness. Because immigrants' circumstances are generally perceived as brought upon them by choice, "they are less likely to be viewed by policymakers as inherently deserving of social and health services," thus, moral assessments deem it necessary to exclude undocumented immigrants from public health care services (Bianchi, Oths, and White 2019, 821; Castañeda et al. 2015, 382). Studies on im/migrant health have evaluated community

stakeholders' differing frames of deservingness to understand how people, even immigrants themselves, may rationalize why immigrants are deserving or undeserving of care (Bianchi, Oths, and White 2019; Melton 2015, 2).

Finally, im/migrant health studies also question how immigrant bodies are understood within a legal framework and why such injustices occur on the structural level. In a study of undocumented Latino immigrants' subjective experiences of social exclusion, anthropologists designated undocumented immigrants as embodying states of exception, which sovereign authorities use to rationalize their poor treatment (Gonzales and Chavez 2012, 257). As Agamben (2005) conceptualized, a state of exception refers to the sovereign authorities' power to strip an individual or a group from the legal and moral protections usually accorded within the state (De León 2015, 27). Despite the waived rights, those same individuals or groups are still deemed punishable by the sovereign authorities' law; such a state mirrors how the United States excludes immigrants from public benefits and rights, yet simultaneously force them through the court system for breaching anti-immigration laws (De León 2015, 109).

#### *Farmworker Demographics and Health Status*

Approximately 2 million to 5 million farmworkers form the labor force behind the production of grains, field crops, fruits, and vegetables in the United States (Villarejo 2003; Doyle et al. 2006). According to the United States Department of Labor research in the National Agricultural Workers Survey from 2001-2002 (NAWS), 75% of farmworkers were born in Mexico, and 53% of all respondents were "working without recognition by the immigration authorities" (Department of Labor 2005, 3). However, research has established that low estimates of unauthorized immigration status must consider how multiple factors, like fear of deportation, impact the estimation's accuracy (Farmworker Justice 2019, 1; Loue and Quill 2011, 104).

Another report states that at least six out of 10 farmworkers are unauthorized immigrants, showcasing the agriculture sector's historical legacy of depending on foreign labor (Bauer and Ramírez 2010, 4; Wainer 2011, 2). With that said, scholars have contested the accuracy of existing farmworker demographic data. For instance, Findeis et al. (2002) found that sources, such as the National Agricultural Workers Survey (NAWS) and the Current Population Survey (CPS), create different demographic results by working with different survey samples.

It is also important to note that not all farmworkers identify as Hispanic or Latino. For instance, the 2001-2002 National Agricultural Workers Survey (2005) calculated that 16% of its 6,472 respondents identified as "belonging to an ethnic group that was not Hispanic or Latino"; in terms of race, the study found that four percent self-identified as Black, eight percent as American Indian, Alaskan Native or Indigenous, and 41 percent as White (4). Within the historical context of southern farm work, Black Americans play a significant role, as "formerly enslaved African Americans and their descendants" made up most of the farmworker population in large farms and plantations (Marquis 2017, 5). Notably, Florida's farmworker demographics have fluctuated throughout the 20th century. Before the late 1970s, African American farmworkers composed most of the population; however, the following decades saw an increase in immigrant workers from Haiti, Mexico, and Central America (Marquis 2017, 8). Nevertheless, recognizing Black American farmworkers remains crucial to the discussion of farmworker issues, especially considering that they currently form significant populations in Florida areas such as Apopka and Hastings. Their legacy represents the shared history of agriculture and slavery (Unsel 2020).

Studies on farmworker communities' social and health status consistently report poverty as endemic among this labor force (Doyle et al. 2006; Grzywacz 2009, 160). The United States'



agricultural industry is structured to underpay farmworkers and disqualify them from being entitled to overtime pay; as a result, more than half of farmworkers live poverty, earning “less than \$7,500 annually” (Doyle et al. 2006; Wiggins 2009). Moreover, agriculture is one of the most hazardous occupations in the United States, causing farmworkers to experience negative health outcomes (Bechtel et al. 2000).

Occupational injuries caused by repetitive movement or equipment accidents are common, as are skin diseases and respiratory illnesses triggered by pesticide exposure (Arcury and Quandt 2007, 348; Rosenbaum and Shin 2005, 14). Heat stroke can also occur to farmworkers due to working conditions, as shade and water breaks requirements are often not enforced in the agricultural industry (Bauer and Ramírez 2010, 13). Such negative health outcomes, influenced by working conditions and poverty, are further compounded by the substandard housing problem observed in farmworker communities, through which infectious diseases become widespread (Rosenbaum and Shin 2005, 14).

#### *The United States' Immigration Policy and its Effect on Farmworker Health*

Although the United States' food system depends on immigrants "more than any sector of the United States' economy" (Wainer 2011, 1, 3), immigration-enforcement laws are creating hostile labor conditions that effectively threaten the health of all farmworkers, regardless of legal status. As Kline's (2017) ethnographic fieldwork suggests, punitive immigration policies produce a level of fear and anxiety that may shape unauthorized immigrants' preventive health behaviors, access to health care systems and, consequently, sustain health inequalities (404). For example, immigrant workers' fear of deportation makes them reluctant to access federal benefits, barring them from accessing the few benefits they qualify for, such as emergency medical services (Bauer and Ramírez 2010, 8; Maldonado 2016, 41). Additionally, unauthorized farmworkers are

unwilling to complain against wage theft or dangerous working conditions, as their employers may threaten them with deportation (Bermudez 2012, 18). Overall, fear of detection can deter unauthorized farmworkers from maintaining their health, which manifests into poor health outcomes, high rates of physical injury and illness at the workplace, and mental illness (Arcury and Quandt 2007, 346).

Immigration-enforcement laws exclude unauthorized immigrants from qualifying for federal government benefits, meaning such laws prohibit unauthorized farmworkers from receiving welfare, food stamps, housing assistance, unemployment benefits, Medicaid, and Social Security (Bauer and Ramírez 2010, 8). Farmworker communities are generally known for their migratory patterns and immigration status; therefore, immigration-enforcement laws at the federal level do target a large population of farmworkers and, consequently, limit their access to mainstream health care services (Arcury and Quandt 2007; Rosenbaum and Shin 2005, 3).

Regarding the anti-immigrant sentiment in federal policies, research has shown that barring non-citizens from affordable government-funded health care is unlikely the key to reducing immigration and more likely to place immigrants and their local communities at considerable health risk (Berk et al. 2000, 51; Willen, Mulligan, and Castañeda 2011). Furthermore, a public health study has found that both farmworkers and health providers recognize anti-immigration policy as a common contributor to health problems, explaining that even authorized farmworkers fear being singled out by law enforcement (Doyle et al. 2006, 284). Some scholars argue that excluding unauthorized immigrants from health care is an intentional act of immigration deterrence. For instance, previous anthropological research has focused on how immigration policies use fear to target unauthorized immigrants' health and force them to self-deport (Kline 2017; Alexander and Fernandez 2014).

### *State and Local Organizations' Role in Farmworker Health Care Delivery*

The responsibility of providing affordable and humane health care has shifted from the federal level to the state, local, and philanthropic level, due to the United States' for-profit health care system (Okie 2007, 526; Portes, Light, and Fernández-Kelly 2009, 19). For example, the United States is seeing a growing network of free clinics, which are generally developed to provide care for uninsured populations (Darnell 2010). As Portes, Light, and Fernández-Kelly (2009) describe it, farmworkers, and unauthorized immigrant workers in general, are confined to “the health care floor,” which is composed by a limited number of resources and volunteer practitioners who are available to offer their services outside of the United States' for-profit health care structure (19). Notably, 22% of farmworkers reported receiving assistance from community-based-charitable organizations in 2004 (Cason, Snyder, and Jensen 2004). Similarly, Okie (2007) emphasizes that some states, such as Illinois, New York, and California, have responded to the lack of federal services by using state funds to include low-income immigrant families and unauthorized pregnant women and children under health insurance coverage (526).

For immigrant farmworker communities, activists identify state governments and local organizations as their main sources of health care support (Wainer 2011, 3). Anthropologists highlight the importance of studying the relationships between these local communities and immigrant populations to understand local infrastructure changes, units of identity, and health care systems in a migrant studies context (Willen, Mulligan, and Castañeda 2011; Contreras and Griffith 2011; Castañeda 2010). Some examples include Griffith's (2009) analysis of immigrant farmworker unions, which details the importance of community integration in developing immigrant farmworkers' social consciousness and social networks. Others have studied local community health providers' perceptions to assess the effects of increased border policy

enforcement (Alexander and Fernandez 2014) or to analyze the frameworks used to describe an immigrant's level of deservingness of care (Bianchi, Oths, and White 2019). Overall, anthropologists have acknowledged the vital role of local community organizations in developing the infrastructure needed to support immigrant populations' social, economic, and health needs (Griffith 2009).

### *Parallel Health Care Systems and Two-Tiered Health Care*

In her review of the concepts and methods of im/migration health studies, Castañeda (2010) suggests that the parallel or two-tiered health care systems phenomenon demands scholarly attention; her reasoning stated that such systems impart much-needed information on the inner-workings of the health care system and Americans' attitudes toward health care reform (12). Within her review, Castañeda (2010) argues that structural inequalities force volunteer-driven health systems' emergence. To support her argument, Castañeda (2010) explains that Germany's public health care system excludes unauthorized migrants; thus, unauthorized migrants must rely on free community clinics for care (13). A parallel, or two-tiered, health care system emerges from unauthorized immigrants' reliance on community clinics. Such parallel systems exist in stark contrast to the "private physician practices, urgent care clinics, and public health departments" that care for the general public with better quality services (Castañeda 2010, 13). Through her example, it is clear how a state's anti-immigration policies create health access disparities, forcing communities to compensate by organizing informal yet more accessible medical systems.

The terms "parallel health care systems" and "two-tiered health care systems" are used interchangeably in Castañeda's (2010) review, but some differences between the two concepts exist. For example, Alves and Timmins (2003) discuss two-tiered health care systems without a

single mention of volunteer-driven clinics and unauthorized immigrant populations. Instead, their work examines how Brazil's health care system is divided into two tiers: the private health care tier and the public health care tier. They found that Brazil's public health care structure suffered from difficult access, long waiting times, and long travel distances, which negatively impacted low-income populations and certain racial groups' health (Alves and Timmins 2003, 3). Even though Alves and Timmins (2003) observed that Brazil's public health care system's quality is quite low, they found that moving toward improved medical care remains virtually impossible for low-income populations (15). Similarly, Davidson (2006) described Canada's two-tiered health care system as a "system of expedited privately financed patients and patiently waiting public patients," referencing how high-income populations have guaranteed access to quick and quality care due to their socioeconomic status (30).

Indeed, scholars broadly apply the two-tiered health care concept to discuss different levels of health care access, specifically based on people's socioeconomic or legal status. Within the im/migrant health literature, two-tiered health care refers to the ways legal status informs and shapes one's access to health care. The two tiers concept also shows how legal status separates unauthorized immigrants from the general public. For example, Castañeda (2010) states that some volunteer-driven health clinics are "not sought out by the general public and exist exclusively to provide medical aid to the unauthorized" (13). From this description, it is possible to see how excluding unauthorized immigrants from a state's public health care system essentially divides its medical system into two tiers: the public health care system for the authorized population and its parallel health care system for the unauthorized population.

In truth, parallel health care systems can refer to different contexts, varying from informal makeshift clinics to traditional healing systems (Kline 2017, 403; Kale 1995). With that

said, the parallel health care systems observed in immigrant worker communities and discussed in this study have three distinctive characteristics. First, these parallel health care systems are characterized by their reliance on volunteers, who give their time freely "to benefit another person, group, or organization"; the arbitrary nature of volunteerism contributes to the informality of parallel health care systems (Linke, Heintze, and Holzinger 2019, 2; Wilson 2000). Second, parallel health care systems parallel formal health centers' organizational structures and attempt to provide similar basic services (Biswas et al. 2011, 10; Sigvardsdotter 2012, 95). In contrast to formal health care systems, however, parallel health care systems provide care to people who are barred, either legally or financially, from benefiting from the government-sanctioned health care system. This particular clientele is perhaps living in poverty, unrecognized by the state (i.e., undocumented status), or ineligible for health insurance; some may be a combination of all three factors individually or due to their family's mixed-documentation status. Third, although parallel health care systems depend on "informal networks of health care professionals" to mimic the role of public health care providers, these informal networks may be formalized through its funding sources or normalized through society's celebration of such humanitarian models of care (Biswas et al. 2011, 10; as cited in Woldie and Yitbarek 2020, 5; Castañeda 2010, 13).

Overall, studying parallel health care systems helps understand health inequalities, as their existence provides multiple theoretical implications of larger social structures. Notably, Castañeda (2010) argues that the normalized existence of such parallel systems in the United States implies that our health care system is accustomed to inequality (12). Furthermore, she believes that Americans who oppose universal health care rationalize their conservative views by believing that volunteer-driven health care is a sufficient care model; thus, everyone has some

access to care. However, studies show that parallel health care systems offer limited services in comparison to state or privately monitored models of care (Castañeda 2010, 13; Biswas et al. 2011, 10). Additionally, Biswas et al. (2011) argue that the existence of parallel health care systems may encourage governments to pass on the responsibility of providing care to underserved communities onto volunteer humanitarian organizations (10). These findings inspired me to verify if community stakeholders currently participating in parallel health care systems perceive these same observations made by previous scholars.

Although Castañeda (2010) suggested that im/migrant health research should focus on parallel health care systems over a decade ago, there is a noticeable lack of research focused on the emergence of parallel health care systems within farmworker communities. While previous research has looked into parallel and two-tiered health care systems within immigrant communities (Castañeda 2010; Kline 2017; Biswas et al. 2011; Sigvardsdotter 2012) and investigated community stakeholders' perceptions on the matter (Dauvrin et al. 2019; Harthorn 1998), more research is needed to understand parallel medical systems within farmworker communities through the perspectives of its stakeholders. Indeed, farmworker communities represent a diverse population, with differing legal statuses, ethnicities, and languages; however, scholars have identified poverty as largely endemic within farmworker populations nation-wide, and unauthorized workers make up approximately 1.1 million of the farming workforces (Grzywacz 2009, 160; Wainer 2011, 1). Since parallel health care systems research usually focuses on how unauthorized status or low-income status impacts health care access, this labor force represents a highly relevant and important population to consider when discussing parallel health systems in the United States.

Additional research is needed to investigate why parallel health care systems emerge in farmworker communities, and grassroots staff members and health care practitioners represent an ideal community to begin this exploration. I aimed to fill this research gap by collecting community stakeholders' perceptions of parallel and two-tiered health care systems. The analyzed results showcased a shared perception of parallel health care systems as necessary to bridge gaps of need, mainly due to farmworkers being socially abandoned by the government (Biehl 2005). Simultaneously, they agreed that parallel medical systems cause the United States' health care system to diverge into two tiers, and their discussions integrated the role of both legal and socioeconomic status as compounding factors causing the second tier's emergence.



## Chapter 3: Methods

This study focused on understanding current perceptions of farmworker health through interviews with members from grassroots organizations and the health care field; the study's populations are also referred to as community stakeholders to talk about both occupations. I collected qualitative data on how farmworker health issues are explained and perceived through nine semi-structured interviews (O'Reilly 2012, 120). The data collected was then divided into two distinct groups that represented the participants' occupations: 1) grassroots organization staff and 2) health care practitioners. By dividing the participants according to their occupations, I conducted a comparative analysis that identifies the similarities and discrepancies between both groups' perceptions on the same topics. Thus, this chapter discusses why I chose these research methods to produce a comparative analysis on farmworker health and parallel health care systems. Overall, this chapter describes the tools for data collection and qualitative analysis, the participant sampling and recruitment process, and the effect of COVID-19's restrictions.

### *Data Collection*

Recorded interviews were the study's sole data collection tool. I conducted five individual interviews with health care practitioners, plus one group interview and three individual interviews with grassroots organization staff. In detail, the only group interview conducted involved a meeting with two grassroots organization staff members simultaneously. In total, I conducted and recorded nine interviews with ten unique participants (with the participants' verbal consent) to collect the community stakeholders' perceptions. For this study's purposes, perception refers explicitly to how the community stakeholders explain and understand farmworkers' needs, the causes for perceived farmworker health disparities, parallel health care systems, and their ideal solutions for the farmworker population.

All nine interviews included around 20 pre-determined interview questions, like "How does providing health care to farmworkers look like within your occupation? From your perspective, what do you think are the most urgent needs of farmworker populations?" By fixing the interviews with pre-determined questions, it became clear when participants yielded unique answers to similar key questions (O'Reilly 2012, 120). Thus, the interviews assisted with the study's comparative analysis, as the results were analyzed side-by-side to identify any similarities and discrepancies between the two groups' answers.

Although I used a pre-determined set of questions, I equally encouraged participants to bring up topics unrelated to my questions. For this reason, the interviews were semi-structured to give way to informal discussions of the topics and allow them to answer the questions on their terms (Cohen and Crabtree 2006). Additionally, participants were able to discuss the topics they find significant to farmworker health issues. For example, some participants discussed racism in the United States unprompted, as they perceived the topic as significant to understanding the current state of farmworker health. In essence, the semi-structured interviews allowed for exploring the subjective meanings that form the community stakeholders' perceptions (O'Reilly 2005, 71).

The interviews were exclusively conducted through phone calls, Zoom Audio calls, and Zoom Video calls to reduce the spread of COVID-19 (CDC 2021). Typically ranging from 40 to 80 minutes, the interviews aided in revealing, as O'Reilly (2012) terms it, an "insider's view" on farmworker health and parallel health care systems (120). Usually, as a participant answered questions, I took notes of the topics they mentioned to ask them impromptu follow-up questions. In other words, while every interview revolved around the same fundamental questions, new questions were also adapted to the ideas freely introduced by participants. As a result, each

interview brought forth "new yet relevant" topics unanticipated in the study's proposal (O'Reilly 2012, 121).

The data collection phase lasted five months, beginning in June 2020 and ending in October 2020. One interview was conducted in Spanish, while the other eight were conducted in English. No follow-up interviews were conducted due to time restrictions. Lastly, I manually transcribed six out of the nine interviews to assist with the qualitative analysis; after I transcribed the sixth interview, I reached the saturation of the data set and found the "information necessary to answer the research questions" (Lowe et al. 2018).

### *Participants*

#### Participants' Occupations and Affiliations

Ten participants contributed to the study's data collection, divided into five health care practitioners (Table 1) and five grassroots organization members (Table 2). In detail, the participating health care practitioners were affiliated with different institutions, such as differing universities (both within Florida and outside of Florida) and community health organizations. Overall, the practitioners represented different medical practice subfields but shared a typical quality: they collaborated with the Farmworker Association of Florida (FWAF), and worked with farmworkers through collaborative research, health programs, or the FWAF free health clinic.

As for the participating grassroots organization members, four of these participants hailed from the FWAF, a statewide non-profit organization with over "10,000 Haitian, Hispanic, and African American members and five offices in the state of Florida with a 35-year history of working for social and environmental justice with farmworkers" (FWAF 2021). Meanwhile, one participant

represented a second organization, WeCount!, a "membership-based workers' center" located in South Florida (WeCount! 2021).

The two organizations varied in their location within Florida, but shared similar goals and missions focused on advocating for the rights of farmworkers, immigrants, and low-wage workers in Florida. The participants' roles and responsibilities varied depending on the organization. For example, a participant from FWAF characterized their organization's work as five buckets: 1) immigration reform, 2) health and safety, 3) workers' rights, 4) food sovereignty, and 5) research partnerships with academic institutions. Through these buckets, the organization members embody different roles at the same time. Similarly, the participant from WeCount! divided their organization's work through three buckets of 1) advocacy, 2) services, and 3) organizing.

Because of the diversity within the workplace of both occupational fields, the population's demography varied. However, participants' demographic information (age, gender, ethnicity) was not systematically collected or included in this study to prevent them from recognizing each other. For the same purpose, I also replaced their real names with pseudonyms. The probability of recognition was high due to the study's snowball sampling (DeCarlo 2019). In other words, the study's sample represented a small network of professionals who knew each other and routinely collaborated to organize farmworker services in Florida.

*Table 1*

<b>Health Care Practitioners</b>	<b>Role Title</b>	<b>Affiliated Institution</b>
<b>Carla</b>	Clinical Instructor/Volunteer at FWAF	University A
<b>Leslie</b>	Clinical Instructor/Volunteer at FWAF	University A
<b>Dana</b>	Researcher	University B

Health Care Practitioners	Role Title	Affiliated Institution
<b>Amy</b>	Clinical Instructor/Volunteer at FWAF	University A
<b>Patricia</b>	Physician	Community health organization and General Medical Field

Table 2

Grassroots Organization Members	Role Title	Affiliated Institution
<b>Nelson</b>	Staff Member	WeCount! Organization
<b>Leonardo</b>	Staff Member	Farmworker Association of Florida
<b>Deborah</b>	Staff Member	Farmworker Association of Florida
<b>Carmen</b>	Staff Member	Farmworker Association of Florida
<b>Teresa</b>	Staff Member	Farmworker Association of Florida

Criteria for Participation

Because this study's research question revolved around the perceptions of people who provide accessible health care to farmworker populations, the study required the participants to hold specific occupations within the health care field or grassroots organizing. As a result, the criteria called for people who are:

1. grassroots organization staff members or frequent volunteers who interact with farmworkers, or,
2. Health care practitioners or health care educators who frequently interact with farmworker patients.

3. Must be 18 years or older.

As can be seen, frequent interaction with farmworkers was a critical criterion for participation in this study. Participants could also be farmworkers themselves, but none of the study participants self-identified as a farmworker. For this study, a "frequent volunteer" is defined as an individual who has interacted with farmworkers through a grassroots organization for at least one year. Equally, health care practitioners were expected to have at least one year of experience with treating farmworkers. Due to the study's sampling methods, all of the participants had years of relevant experience.

#### Sampling Methods and Recruitment Process

Non-probability sampling techniques were employed to select the participants of this study. While non-probability samples are not known to yield data that is "truly representative of a larger population," they are useful for the study of unique personal experiences, which relates to this study's focus on subjective perception (DeCarlo 2019; Sparks, n.d.) First, I used purposive sampling to select participants with desired characteristics like, for example, frequent interaction with farmworker populations (DeCarlo 2019). Other characteristics coveted from participants included their occupation (as detailed above) and participation at free health care clinics targeting farmworkers. In general, this method was used by purposely contacting specific grassroots organizations that held staff who generally met these qualities and asking if the organization was interested in being part of this study.

Second, I incorporated snowball sampling into this study due to my relationship with the study's key-informant (DeCarlo 2019). That is to say that I was fortunate enough to build a relationship with a key informant from the Farmworker Association of Florida. Because of that

relationship, I was introduced to the key informant's network of staff members and health practitioners via E-mail.

Indeed, the study's sole recruitment process revolved around the key-informant helping identify additional study participants and e-mailing them the study's short description and flyer yet remaining unaware of who agreed to participate (DeCarlo 2019). Notably, self-selection sampling (where participants' inclusion or exclusion is determined by their agreement or refusal to participate in the sample) was also incorporated into the study (Lavrakas 2008). Ultimately, snowball sampling was chosen as the study's sole recruitment method because COVID-19 restricted me from meeting and recruiting potential participants face-to-face.

#### *The Impact of COVID-19 on the Study's Design*

This study was conducted through the internet using E-mail and videotelephony to adapt to the limitations that the COVID-19 pandemic placed on face-to-face contact. Under such circumstances, it became difficult to build an ethnographic data set since traditional ethnography also relies on participant observation to study people within the context of their communities (Emerson, Fretz, and Shaw 2011, 1; O'Reilly 2012, 28). As a result of the pandemic, I changed the study's approach to its research questions, participant observation methods, document analysis methods, and field site.

Virtual ethnography, or a study through virtual communication, may describe the type of ethnography conducted in this study. However, anthropologists have debated about the effectiveness of virtual ethnographies, as it lacks contact with participants' daily lives and differs from "established model[s] of anthropological field study" (O'Reilly 2012, 176; Hannerz 2019, 180). For example, O'Reilly (2012) considers interviews as ethnographic when they are based on meaningful relationships with participants, conducted multiple times in informal and formal

environments, and supplemented by participant observation data (127-128). Unfortunately, this study was unable to conform to such standards via virtual communication.

Certainly, the study's one-time semi-structured interviews provided a data set that was rich with subjective meaning, thanks to the participants' thoughtful answers. However, the interviews provided little information to explain why grassroots organization members and health care practitioners may hold similar or different perceptions. Participant observation may have yielded such answers by observing community stakeholders' job responsibilities, roles, and time spent with farmworkers.

Participant observation, which is considered the "main method of ethnography," was not included as a data collection tool to reduce the risk of spreading the COVID-19 virus (O'Reilly 2012, 86). On March 9, 2020, Governor DeSantis declared Florida to be in a State of Emergency due to the worsening COVID-19 pandemic (Florida Health 2020). Through the entirety of the study's five-month data collection stage, Florida remained in the State of Emergency, an order that exhibits the pandemic's severity (Nichols 2020). According to the CDC (2021), the virus is "mostly spread by respiratory droplets," and "the more people an individual interacts with at a gathering and the longer that interaction lasts, the higher the potential risk of becoming infected with COVID-19 and COVID-19 spreading." Thus, participant observation, a method characterized as spending a "great deal of time" with people and participating in their daily lives, became unfeasible during the pandemic (O'Reilly 2012, 96).

The document analysis method included in the study's proposal was also deemed unfeasible and replaced with a close reading of the literature review. Virtual ethnographies often collect online platforms' documents to supplement their data set (O'Reilly 2012, 175). However, this study's population sample represented a multilocal network of community stakeholders



(Hannerz 2019, 180). Identifying relevant documents online became complicated when, as a whole, the participant sample represented six different work environments. It became even more challenging when the pandemic limited my access to the participants and field data. Hence, the study shifted its focus towards categorizing and comparing the interview data, supplementing the data results with current literature findings.

Finally, as a virtual ethnography, this study took a different approach towards understanding its field site, which was 1) inaccessible due to the pandemic and 2) multi-sited due to the participants' different job locations (Hannerz 2019, 180). Notably, limitations on travel and face-to-face meetings resulted in a lack of interaction with the participants' communities and working environments. Nevertheless, virtual communications allowed participants from Florida and even outside of the state to participate and share their perspectives. In that case, a virtual ethnography approach seemed to fit this participant sample's needs, as many of them are affiliated with multiple universities and community health centers across Florida and beyond state lines. Rather than considering the study's field site as a specific area, this study focuses on the relationships that exist within the multiple field sites, specifically the rich network of multiple grassroots organizations and health care practitioners that are "not confined within some single space" (Hannerz 2019, 180).

### *Data Analysis*

Semi-structured interviews with community stakeholders produced a qualitative data set rich with subjective meanings, explanations, and perceptions of farmworker health. This study employed a contemporary grounded theory approach to analyze its data set. The grounded theory proposes a data coding procedure that directly creates analytical categories from the data, rather than relying on preconceived concepts (Emerson, Fretz, and Shaw 2011, 172; Gobo 2008, 2).

Gobo's (2008) interpretation of Corbin and Strauss' grounded theory was applied during the data analysis to assist in organizing, coding, and analyzing the data.

As I transcribed the interviews on my computer, I simultaneously conducted open coding by manually taking notes of the potential themes, categories, and concepts (Gobo 2008, 4). Code memos were written by hand during the transcription and open coding process, which helped identify general patterns and link bits of data to formulate the study's final analysis (Emerson, Fretz, and Shaw 2011, 194). Finally, axial coding reassembled the concepts into "a new pattern" using Castañeda et al.'s (2015) structural framework to describe the community stakeholders' perceptions as structurally informed (Gobo 2008, 11).

This study adapted Castañeda et al.'s (2015) primary immigration and health studies' primary frameworks to categorize and analyze community stakeholders' differing perceptions properly. Although these frameworks were originally developed to describe how scholarly articles portray and explain immigrant health, the "assumptions, topics, and outcomes" delineated in each framework also helped understand community stakeholders' perspectives (Castañeda et al. 2015, 379). By adhering to the characteristics delineated in each framework, this study produced an analysis consistent with previous anthropological findings on immigrant health.

Additionally, the constant comparison technique helped build the study's comparative analysis. As the coding process progressed, grassroots organization members' answers were compared to healthcare practitioners' answers on a case-by-case basis. The interview answers' different properties were interpreted as similarities or differences between the two groups (Corbin and Strauss 2008, 8-9).

The methods discussed above resulted in a data set that I compared, contrasted, and analyzed qualitatively using the NVivo 12 software. Altogether, it is essential to note that this study's analysis is not an authoritative representation of the population sample's reality but instead represents my subjective interpretation of the data (Emerson, Fretz, and Shaw 2011, 190). Nevertheless, the data analysis attempted to stay as close as possible to the participants' answers.

## Chapter 4: Perceptions of Farmworker Health

Leonardo had never conducted a study with human subjects until he joined the Farmworker Association of Florida (FWAF) as an assistant researcher in 2016. He shared this statement, then paused, and added with amusement: “Well, I hate to refer to farmworkers as human subjects but...” In collaboration with FWAF, a grassroots organization with a state-wide reach in Florida, Leonardo researched the effects of heat stress on farmworkers’ bodies. He describes this experience as both grueling and eye-opening since his responsibilities included following the early farmworker work schedule and collecting information on specific agricultural activities:

“[...] But I feel like I learned a lot. I learned a lot about the working conditions, what they have to go through, and again—here we are, just meeting them at four in the morning, but for a short data collection period. [They] are doing this day in and day out.”

He relayed what he learned about agricultural activities in the form of a list: sitting, squatting, planting, picking, harvesting, moving plants, plotting, and “driving a rebar into the ground just to help the tomato vine grow.” A rebar, to clarify, is a metal stake installed by farmworkers into garden beds “to hold plants tied with nylon strings,” done multiple times in a season (Wang, Liu, and Zhang 2020).

After a long and strenuous workday, many farmworkers in Florida take the bus and arrive home after two to three hours. “To think you’re sitting in a bus for four hours in a day, not getting paid, just to make it to the place where you’re going to be working, and then still be only paid like a piece rate, which comes up to just over a minimum wage,” Leonardo mused before continuing, “and I think that the other thing that impacted me, as I learned more about the project, is that it wasn’t just the physical activities, but the dehydration. And that’s really what

was at the core of the study. The long-term effects of constant dehydration, lack of access to water and to bathrooms, and what that did to their kidneys.”

It is essential to realize that Leonardo refers to the “lack of access to water and bathrooms” as the core of poor farmworker health outcomes, rather than focusing on their physical activities (sitting, squatting, planting...). In contrast, previous research has recorded community stakeholders blaming farmworkers for their poor health, such as physicians stating, “indigenous people bend over too much at work” (Holmes 2013, 148). Similarly, Horton (2004) noticed how New Mexico health care providers expected immigrant patients to assume responsibility for “managing their own behaviors and health status” (478).

Even though scholars believe that many corporations depend on keeping wages low and workers injured to achieve maximum profitability, it is common for community stakeholders to view large-scale social systems, like the agricultural business, as “morally and socially benevolent” (Guthman 2017, 31; Jain 2006, 48; Saxton 2015). Thus, considering individuals’ behaviors as the main source of poor health outcomes is a common perception, especially within immigrant public health literature (Castañeda et al. 2015). However, as can be seen from Leonardo’s focus on large-scale social factors, this study’s network of community stakeholders expressed differing attitudes from the ones discussed above.

#### *Structural Explanatory Factors: The Social Determinants of Health*

Leonardo’s experience not only encapsulates how he understands farmworker health, but also represents a key perspective shared by most of this study’s participants: farmworker health is primarily influenced and afflicted by the systems and policies in place, which expose farmworkers to unsafe and exploitative work environments. Resulting from these policies and systems are a series of social determinants of health, such as 1) farmworker labor policies, 2)

immigration status, and 3) socioeconomic status, which further constrain farmworkers from maintaining their health. This section will survey the participants' thoughts on these three social determinants of health and how the determinants materialize into poor farmworker health outcomes.

### Farmworker Labor Policies

Many participants directly referred to the social determinants of health as their lens through which they view farmworker health. Conversely, other participants did not mention the social determinants of health directly but either alluded to them in their explanations or agreed with the approach when I mentioned it. Illustrating her view on the social determinants of health is clinical researcher Dana, who answered:

“The term social determinants of health has been kind of trending right now. It is used a lot, but I think [those] social determinants of health are really driven by [policies] that are in place. And so, when a community doesn't have political power or is marginalized, it's difficult for the social determinants to improve. So, it's important to keep the political system in mind and the policies in place that contribute mainly to driving the social determinants of health and driving for certain minority communities to have health disparities.”

Dana explained how undocumented farmworkers or mixed-status farmworker families are barred from receiving financial aid during the COVID-19 pandemic when asked to expand on the types of policies currently restraining farmworker health,. “We call them essential workers, yet we are not prioritizing that they get stimulus money, we're not prioritizing that they get COVID-19 testing on a regular basis,” she stated, reaffirming the need for large-scale social factors to protect, rather than ostracize, farmworkers.

Dana also explained how a lack of policies is equally harmful: “Farmworkers or outside workers do not have federal heat protection standards. So, there’s no policy to protect workers while they’re working in the heat. There’s no policy that [says that] they have to have breaks, or that employers have to provide water and bathrooms. So that leaves two to three million agricultural workers vulnerable.” The lack of farmworker protective policies is, in fact, explained by the United States’ history of systemic racism. For instance, Marquis (2017) explains that Congress purposely excluded agricultural and domestic workers from fair treatment laws, such as the rights to organize, minimum wage, overtime compensation, and so forth, because Black Americans populated those occupations; awarding them rights would have upset the United States’ economy built off exploitation (7). While the United States has amended the minimum wage law, they are not as strictly enforced. Additionally, farmworkers remain without the usual employment benefits, like health insurance, disability insurance, paid time off, or retirement, even as they continuously pay the nation’s taxes (Marquis 2017, 7).

The lack of protective labor policies in the agricultural system is further compounded by the fact that farmworkers’ legal status or socioeconomic status grants them minimal power when speaking out against dangerous working conditions. For instance, previous research has documented how farmworkers’ low socioeconomic status forces them to depend on their agricultural job; farmworkers fear being fired and losing their wages for complaining against the farm’s dangerous pesticide exposure or minimal water breaks (Ramos 2017, 47). As a result, farmworker health is then negatively shaped by the farm’s unregulated occupational hazards, such as heat stress and pesticide exposure.

Multiple participants also discussed heat stress and the cause of its prevalence through a structural view. In general, participants perceived heat-related illnesses as a health issue of

growing concern and importance. For example, FWAF staff member, Deborah, reported that their organization “recently included heat stress” as part of their health and safety work. Nelson, a WeCount! staff member, detailed his view on the current state of heat stress: “I think heat stress has to be at the center of our minds.” To express the urgency and danger of heat stress, Nelson detailed the effect that the illness has on agricultural workers’ bodies:

“The effects of extreme heat: organ failure, fatigue, dehydration, muscle cramping, all that stuff. It is happening and it’s happening in the middle of this summer.”

Pesticide or chemical exposure was equally perceived by participants as a real occupational hazard alongside heat stress. For clinical instructor Carla, heat stress and pesticide exposure represent one of farmworker’s most urgent needs that require immediate mitigation. Specifically, Carla stated that farmworkers urgently need protection from both occupational hazards to be able to “maintain their health.” WeCount! member Nelson provided a similar answer when asked about the urgent needs of farmworkers. Alongside discussing other urgent needs like basic COVID-19 protections, higher wages, and affordable housing, Nelson described how farmworkers urgently need to be protected from “hazardous work conditions” such as heat stress and pesticide exposure.

The participants based their concerns on the fact that such precarious working conditions may trigger negative health outcomes and, subsequently, worsen them. For instance, FWAF member Deborah detailed how, according to recent research, pesticide exposure plays an important role in the development of diabetes (Evangelou et al. 2016). Clinical researcher Dana stated that farmworkers who work outside in the sun are sustaining kidney injuries while they are working, yet the direct cause for the illness remains unknown. Furthermore, clinical instructor Leslie discussed how heat exposure further worsens a farmworker’s health, especially when farm



work's low wages restrict them from accessing health care and medication. Notably, Leslie considered how multiple social determinants of health might interact to produce dangerous health outcomes.

On the whole, participants routinely mentioned the unregulated and hazardous state of farm work to explain the occurrence of poor health outcomes. However, the blame was rarely, if ever, on the farmworkers' individual actions. Instead, the occupation's overall structure and lack of benefits were perceived as a barrier to health care and the cause for poor health outcomes. To demonstrate, FWAF member Deborah described the following:

“Farmworkers work really long hours and really long days, but the vast majority of farmworkers do not have health insurance. And so, access to health care is a really big problem. A lot of them live in really remote rural areas, so getting to a clinic or someplace where they can get health care can be really difficult.”

Similarly, clinical instructor Carla related the job's responsibilities, as well as its lack of benefits, to farmworkers' struggle of maintaining their health, stating “you're already a farmworker, so it's hard enough, to get—maybe their work hours are a little bit harder to get to a regular office that's nine to five,” further along adding that “[farmworkers] don't have the luxury of, okay, I have [paid time off] and vacation time.” Carla ended her thought by stating that, although she wasn't too aware of agricultural work's specific job benefits, she understood that low-wage jobs generally bar people from managing their health.

This section's introduction showed how FWAF member Leonardo perceived a lack of policies protecting against occupational hazards as the core of poor farmworker health problems. This belief was shared by other participants, such as WeCount! member Nelson, who said:

“If we do not resolve what happens in the workplace, if workers do not have the protections they need, the wages they deserve, if employers are not held accountable to certain health and safety standards, all of that inevitably informs the workers’ health, because workers spend the majority of their waking lives at work.”

Comparatively, at the core of the participants’ perceptions is a concern for the structural forces that inform farmworker health. As a result, the grassroots organization, FWAF, has advocated for and, consequently, achieved better worker protection standards through the United States Environmental Protection Agency (EPA) (FWAF 2021); however, concerns remain around the enforcement of such policies, as FWAF member Deborah states:

“But there’s still an issue with compliance and enforcement of those regulations. And then there’s still more and more pesticides being approved, so, even though the protections on the books are better, [it] doesn’t mean that farmworkers aren’t getting exposed. [Because] of anti-immigration sentiment, there are more afraid to report pesticide illness.”

Indeed, FWAF member Deborah articulates a point commonly discussed within the interviews, which is how documentation status may interfere with a farmworker’s ability to maintain their health. As stated above, the lack of policy enforcement, then, combines with undocumented farmworkers’ fear of punitive immigration laws, resulting in many farmworkers feeling powerless in the face of danger in their workplace. Immigration status as a social determinant of health, as understood by the study’s participants, is discussed in the following sub-section.

### Immigration Status

Considering that half of the farmworker labor force is composed of undocumented immigrants, it is understandable why farmworkers’ status was perceived as relevant by the

interviewed participants (Reid and Schenker 2016, 646). Participants perceived specific behaviors, which may be considered as risky or damaging to ones' health, as measures taken by undocumented farmworkers to protect themselves and their families from job loss, family separation, and deportation. Overall, participants perceived anti-immigration policies as systemic barriers that prevent many farmworkers, especially undocumented farmworkers, from consistently maintaining their health.

Research shows that farmworkers, both documented and undocumented, can be psychologically affected by the possibility of being singled out by immigration enforcement officers, therefore many may avoid frequenting health clinics (Doyle et al. 2006, 284). Participants also demonstrated the negative impact that anti-immigration laws have on health by discussing specific policies, such as Senate Bill 168, a state law passed by Governor DeSantis in 2019 which requires local law enforcement to enforce anti-immigration laws and restrict sanctuary policies (ACLU FL 2021); and the federal law of public charge, which penalizes undocumented immigrants from depending on the United States' public resources (USCIS 2020).

WeCount! member Nelson described the Senate Bill 168 as “one of the most anti-immigration laws in the country,” and explained that both the bill and the public charge law reaped confusion, distress, and fear in immigrant communities. “This question of public charge is still seen in the minds of a lot of people who decided to go hungry, to not access resources or support because they don't want to jeopardize their immigration application. So, there's that barrier as well,” stated Nelson, echoing a similar sentiment expressed by FWAf member Deborah:

“So, farmworkers won't seek health [care] if they're afraid that [by] asking for help they're going to jeopardize themselves with immigration. That's in terms of being

themselves deported or family members deported. And then long-term [solutions], I mean huge structural changes. Immigration reform, nationwide, is really important for undocumented farmworkers.”

Fear of anti-immigration laws may worsen the safety problems in the workplace, as stated by Leonardo:

“You may not feel comfortable asking for a bathroom, or water breaks or shade or any of those recommendations because you don’t want to end up being blacklisted [by other] growers in the area.”

FWAF member Leonardo recognized that farmworkers are exposed to a greater risk of health issues by putting their immigration status before their health and empathized with the farmworkers in such difficult positions. In this case, he recalled how an undocumented farmworker was fearful of reporting high levels of pesticide exposure because the act may cause him to lose his agricultural job, be detained, and leave behind his sick spouse. “He had a lot on his plate, and I think reporting pesticide exposure was probably not at the top of his list of priorities,” explained Leonardo.

Clinical researcher Dana answers resembled Leonardo’s statement above; she expressed an understanding of the careful balancing act that farmworkers must uphold to protect themselves:

“The agricultural workers don’t want to walk the boat, let’s say, at their jobs and tell their employers ‘we need more breaks, this is unfair,’ or—because they depend so much on their wages. Their wages are so low that they truly live paycheck to paycheck. And so, the fear of not being able to survive is real.”

Dana’s response touches on how farmworkers are impacted by a combination of factors at once,

such as socioeconomic status and documentation status; indeed, the majority of the participants acknowledged that farmworker health is impacted by multiple compounding social determinants of health.

Such fear of social punishment materializes into problems outside of the workplace as well. Clinical instructor Leslie specifically discussed how farmworker families will avoid taking their children to school from fear that their children will be deported. Even more, during the pandemic, farmworkers were fearful of getting tested due to a rumor claiming that COVID-19 tests would implant a tracker that exposes them to immigration officials. “That level of fear of everyone around you has to be incredibly stressful and we’ve seen children come in with a [stomachache lasting three months] and we get to the bottom of it, and they're just scared! So, that’s just horrible, like, I can’t imagine that level of fear, and it hurts me.”

In other words, participants perceived that risky farmworker behavior is an understandable reaction to the looming negative consequences of anti-immigration laws, and, as FWAF member Deborah stated, only structural reform would change such behaviors. Likewise, participants understood that farmworkers themselves may perceive the acts of reporting safety concerns or frequenting health clinics as riskier for their family’s overall well-being. The separation of family, loss of wages and, as a result of the former, loss of life, are real concerns for immigrant farmworkers. For the interviewed community stakeholders, these concerns stem from structural problems.

Nevertheless, participants simultaneously understood that even when farmworkers sought out public services to support their health, anti-immigration policies could deny them a service. Indeed, when asked about the factors that may cause farmworkers to be vulnerable, clinical researcher Dana answered that undocumented status is one of the biggest causes for their

vulnerability, as it prevents them from accessing affordable health care clinics. Likewise, clinical instructor Carla, who has treated farmworkers through FWAF-hosted health clinics, stated that she experienced shock when she learned that certain community health organizations may deny care to people because of their documentation status.

On the topic of anti-immigration policies, FWAF member Leonardo explained the historical context behind such laws, further showcasing how many participants related farmworker health problems to large-scale social forces. According to FWAF member Leonardo:

“The system is set up so we have a pool of cheap labor, and we need that pool of cheap labor, and for it to be cheap, it has to be desperate. And so, since [the] inception of this country, we have relied on imported agricultural workers.”

In the next sub-section, the final social determinant of health alongside farmworker labor policies and immigration status will be addressed: socioeconomic status. The following sub-section will continue to explore the participants’ structural perception of farmworker health outcomes, specifically how they use these three main social determinants of health and large-scale social structures as their main explanatory factors of farmworker health outcomes.

### Socioeconomic Status

Participants referred to farmworkers’ socioeconomic status as one of the main social determinants impacting farmworker health, an observation consistent with farmworker literature’s agreement that poverty is endemic among farmworkers (Grzywacz 2009). In detail, participants cited socioeconomic issues, such as low wages, as the reason why many farmworkers cannot afford health care, as well as experience difficulties with maintaining a healthy diet. As a whole, participants understood farmworker health as impacted by a combination of a worker’s low wages and the health care for-profit structure. Additionally,

participants perceived farmworkers' choices as restricted by their low-income; at times, participants shared experiences where they witnessed farmworkers forced to sacrifice their health to maintain financial stability. Overall, I found that participants generally used socioeconomic status just as much as immigration status and work policies to explain farmworker behaviors and health outcomes.

The agricultural industry was often recognized as a system that under-compensates its workers. Notably, FWAF member Deborah stated that farmworkers are doing the "most important job in the world," yet are usually "unrecognized and unappreciated, uncompensated and discriminated against." Similarly, clinical instructor Leslie discussed how, regardless of if a farmworker migrates for work or not, the work still pays "really low wages to do awful work." Thus, participants understood farmworkers' low socioeconomic status as a product of the agricultural industry.

They also recognized poor health outcomes as a product of both low wages and the health care structure. To start, participants agreed that low wages, in part, dictate health outcomes, or as WeCount! member Nelson expressed it: "[WeCount!] understands that one of the biggest indicators of worker health is also a worker's wages and their income security." Furthermore, many pointed at the health care system's high costs to explain its inaccessibility to farmworkers. In this case, clinical instructor Leslie identified the cost of health care as the biggest factor making farmworkers vulnerable, then illustrated how socioeconomic status interrelates with the health care structure to produce poor health outcomes:

"So, in [redacted] we have a clinic, a community health care center [...] They're supposed to be low cost. Well, to be seen there, you have to present paperwork that shows an address, that shows different things. So, even if you have the paperwork, you

have to pay on a sliding scale. And a family told us that the dad had gone in to get some lab work done and he couldn't pay the bill, it was \$100. They were going to let him pay in installments. And a few weeks later, their [child] broke [their] arm and they took [them] there, and they wouldn't see the little [child] because they had an outstanding bill.”

As shown through Leslie's example, a farmworker parent's socioeconomic status placed him in a precarious situation where health care was inaccessible to their child. Leslie, then, attributed this chain of events to the structure of the health care system, showing how her perception of farmworker health fit with the structural framework: “Health care has been so long built on insurance and if you have good insurance, you can see the right doctors and you can see—we don't base health care on just the fact that it's a right, which is sad.”

To a great extent, participants echoed clinical instructor Leslie's train of thought. They recognized that the health care system structure and farmworkers' low socioeconomic status compound in ways that limit one's choices. FWA member Leonardo expressed the following, reflecting on the difficult choices farmworkers must make when pressured by expensive health care systems and their low wages:

“I think health care should be more affordable and that if a single-payer health care system is what it takes, then so be it, but I don't think that somebody should have to decide whether they need to pay for food on the table or their health care.”

Similarly, WeCount! member Nelson stated, “the prospect of incurring out of pocket expenses, incurring medical debt, is also in the minds of people who have very little financial freedoms, and have to make these very tough choices with their budgets.”



Some participants acknowledged how farmworkers' choices can be limited by structural factors through examples of prescription use. For example, clinical researcher Dana recounted a story of farmworkers who stopped taking their prescriptions because of a language misunderstanding. According to Dana, the farmworkers believed that prescription refills required returning to the doctor and paying for another office visit. Thus, they chose not to return in fear of incurring any more expenditures. Comparatively, clinical instructor Leslie shared how she has witnessed farmworkers forced to halt their medicine use because its monthly cost was too expensive. As a result, farmworkers returned to Leslie's care with dangerously high blood sugars. As can be seen, Dana and Leslie's stories recognized how socioeconomic status forced farmworkers to sacrifice their health to maintain financial stability; they both connected the farmworkers' behaviors to structural factors.

Participants also exemplified how structural factors restrict farmworker choices by discussing nutrition. Clinical instructor Carla, for instance, agreed when asked if the presence of heart disease and diabetes in farmworker communities is due to their socioeconomic status acting as a social determinant of health:

“I think that probably one of the factors—and [some] of it may be genetic? As far as people being predisposed to diabetes and hypertension [...] but, a lot of it probably has to do with the social determinants. It's cheaper to buy unhealthy foods as opposed to healthier foods.”

FWAF member Deborah answered in like manner, stating that obesity among farmworkers is due mainly to their low socioeconomic status and proximity to areas with limited healthy food options, also referred to as food deserts (Walker, Keane, and Burke 2010). Moreover, FWAF member Leonardo shared his perception on the overlapping systems that result in food deserts:

“I think there’s several things pointing to [the lack of quality food in rural areas]. One is that our food system is driven by profit margins, so a lot of the food that is grown goes to places where it can get a better pay for it. So, just to largely urban areas and [...] neighborhoods where it can be priced a little higher than neighborhoods where it doesn’t get as good a price. So, we end up with a lot of processed foods in rural areas or poor neighborhoods. And also, I think because a lot of farmworkers don’t make a lot of money, so the only food they can afford is highly processed food that is very poor in nutritional value.”

Leonardo’s perspective served to contextualize farmworker health outcomes within the existing infrastructure that currently hurts them. As shown above, participants perceived farmworker health as heavily impacted by low socioeconomic status, which acts as a social determinant of health alongside immigration status and farmworker labor policies.

### *Reflecting on Farmworker Communities*

During the interviews, I asked participants questions about 1) labeling farmworkers and 2) the importance of supporting farmworker communities. For the first question, I inquired if they identified farmworkers as “underserved” or a “community in need,” as the practice is prevalent in farmworker health literature. Additionally, the second question intended to explore the ‘why’ of their involvement with farmworker communities. As will be seen, the questions prompted discussions of agency, resiliency, and deservingness from some participants. Rather than yielding clear-cut answers, the questions revealed the ambiguity and variety of perceptions within this network of community stakeholders. Altogether, these discussions furthered my understanding of the participants’ perceptions, as an analysis on farmworker health is incomplete without considering how the stakeholders perceive the farmworkers themselves.

Through this section, I will compare and contrast the participants' answers and contextualize each perception within the farmworker health literature, using concepts like Escobar's development theories and frames of health deservingness (Escobar 1999; Bianchi, Oths, and White 2019; Melton 2015; Viladrich 2012). The structural framework continues to be the dominant view through which all community stakeholders perceive farmworkers' health; participants reference large-scale social factors to justify their points of view the most. Finally, I answer my second research question and argue that the differences of perception found within this network of community stakeholders are due to participants' individual experiences dealing with farmworker health, rather than the participants' different occupations (i.e., health care practitioner and grassroots organization member).

### The Underserved Label

The prevalence of the term underserved within farmworker literature inspired the addition of the following interview question:

“Do you think farmworker populations are an underserved community/community in need in Florida?”

Indeed, many scholarly descriptions of farmworker populations resemble Bail et al.'s (2012) introductory sentence, “Migrant farmworkers represent one of the most marginalized and underserved populations in the United States,” such as the writings of Doyle et al. (2013), Frank et al. (2013), and Rhodes (2009). Likewise, Villarejo's (2003) literature review of farmworker health concluded that farmworkers remain an underserved community in the United States. In particular, the political definition of the term underserved refers to specific communities or areas in need of health service funds, the need calculated and legitimized by the Index of Medically Underserved (IMU) (Villarejo 2003, 182). According to the IMU, farmworker communities in

California averaged a worrying 61.1, meaning they were eligible for an official designation of “medically underserved” by the federal government (as cited in Villarejo 2003). In essence, the term underserved generally indicates that an area lacks a balanced ratio of primary care physicians and demonstrates a high rate of poverty, making health care inaccessible to the population (Segen’s Medical Dictionary 2021).

Within the literature, the use of the underserved label gave urgency to the topic of farmworker health. For instance, authors used the label to clarify how structural inequalities manifested into unequal access to health care and poor health outcomes in farmworker communities. Thus, the original purpose of the question was to gauge community stakeholders’ perception of farmworker health; I hypothesized that agreement with such labels would indicate that participants perceived structural inequality as the root of farmworker health outcomes. However, the question gave way to unexpected discussions of agency and resilience. For example, FWAF member Leonardo shared how their farmworker friend resisted the label’s implications:

“I was talking to a friend and she said that she didn’t like using the term underserved, because it sort of victimizes the—Or frames everything as a community being victimized. But she said, ‘our communities are—we are survivors, we have 500 years of persistence, and we’re still here.’”

Leonardo’s perspective raised the problem of victimization, which is a complex concept that may imply “passivity and lack of human agency” (Arfman et al. 2016, 4). In contrast to the original hypothesis, rejecting the label did not limit Leonardo from acknowledging structural inequality as a core issue:

“I think there is real need out there that needs to be addressed and some government interventions would be good, but I don’t think that’s our goal. I think our ultimate goal is that communities can serve themselves, so that they have the tools to feed themselves, to protect themselves, to decide for themselves, to govern themselves without being held hostage to outside interest, like profit margins by a corporation.”

Instead, Leonardo highlighted farmworker communities’ agency as the FWAF’s overall vision of social justice and structural reform. Previous scholars have also thought about the possible victimizing effect of labels. Similar to Leonardo’s view, Agustín (2009) argued that rejecting “static, generalized categories” does not ignore structural inequalities; moving past labels recognizes people’s agency and stops outsiders from identifying themselves as a population’s “savior” (60).

For Escobar (1999), labeling certain populations or areas as “third-world countries” eventually persuaded entire communities to perceive themselves as “inferior, underdeveloped, and ignorant” (386). Clinical researcher Dana perceived the underserved and community in need labels in a similar way, as she worried that the labels “highlights negative aspects” of farmworker communities:

“They are underserved in that they don’t have health care; policies have not served them like they’re supposed to be served. But I also think it doesn’t really capture the resiliency of the community, and how strong they are, and how much they—the farmworker community really relies on each other to go forward. [So] I can’t—I don’t know, honestly, what term could capture everything. (Laughs) It’s hard, right?”

Again, both Leonardo and Dana are quick to acknowledge the reality of structural inequality affecting farmworker communities, yet they are careful not to undermine farmworkers’ role in

their survival and social justice advocacy. Dana's struggle with formulating a better fitting term further highlighted the complexity of acknowledging farmworker agency while also holding structural factors accountable for farmworker oppression. Indeed, scholars caution that the structural view tends to simplify reality to a "dichotomous view of 'marginalized victims battling totalizing social structures,'" leaving structural labels like underserved little room to recognize agency (Horton 2016, 5; Slack and Whiteford 2011). Furthermore, agreeing with the label did not mean that participants perceived farmworkers as passive victims of structural inequality.

WeCount! member Nelson stated that farmworker populations are "absolutely" underserved or a community in need. To explain his view, Nelson listed multiple factors that impact farmworker health, such as "the level of income insecurity, the level of poverty, the significant barriers to accessing forms of relief and recovery." Nelson acknowledged how these factors are direct consequences of structural inequality, or, in other words, the government not adequately serving the communities' needs.

His use of the label showcases its value in identifying the root of the issue as structural, which mirrors some scholars' opinion on the term: "[The term underserved] suggests that deficits and problems exist within the health care system and society at large rather than being the fault of individuals and groups involved" (as cited in Beauchesne and Patsdaughter 2005, 78). However, Nelson clarified that WeCount! acknowledges the impact of structural inequalities to "transform those systems," not to replicate charity models, or to act as a farmworker's savior. Rather, WeCount!'s role is to ensure that low-wage immigrant workers are "actively shaping policies at a local and state level that directly benefit them." Thus, Nelson used the label to identify the problem and also recognized farmworker agency.

Clinical instructors Carla and Leslie did not discuss farmworker agency but went into depth about how undeserved communities result from structural inequality's downstream effects. For example, clinical instructor Carla agreed that farmworker communities are underserved; in her experience treating farmworker families, she observed how their rural location and demanding job bar them from accessing health care. She specifically mentioned how regular clinic hours are incompatible with farm work schedules and believed health clinics should be structurally reformed to be accessible and serve farmworker's primary care needs. Additionally, Carla brought up the United States' history with racism and general structural inequality to express how communities in need develop:

“[There] are certain communities that do not have access to health care, that do not have access to good schools, that don't have access to proper housing. [Like] Johnny A and Johnny B, Johnny A is from, let's say, an affluent community, as opposed to Johnny B, [who's] born in a less fortunate community. It's going to take a lot more work for Johnny B, who is born into that community that has less, to make it out in the world. Because they just don't have access to the basic stuff. So, that's what you look at, when you look at communities in need.”

Finally, for clinical instructor Leslie, farmworker communities are underserved in Florida. In her view, health care costs are too high for the general public, eventually resulting in making health care inaccessible to low-income farmworkers. Both Carla and Leslie understood that structural inequalities produce the communities labeled as underserved. They explained their views through detailing specific structural pitfalls, like the health care system's schedule and high costs; this may be due to their proximity to the health care system as clinical instructors, however, it must be remembered that clinical researcher Dana presented a different view.

As can be seen, grassroots organization members shared the same occupation but held different perspectives on the labels; the health care practitioners group saw the same phenomenon. While FWAF member Leonardo was wary of the label's implications, WeCount! member Nelson did not mention the issue of victimization directly. Instead, he agreed with the label and directly stated the organization's intent in highlighting farmworker agency and resiliency. Overall, the participants who shared the same occupations tackled the topic in distinct ways, showcasing how differences in perception may be due to their individual roles and experiences, collected as they each navigate working with farmworker communities. For example, FWAF member Leonardo's perception was influenced by his friend of the farmworker community. With that said, the majority of the participants continued using structural factors to explain their perceptions of farmworker communities and health outcomes; this represents the biggest perception similarity between both community stakeholder groups.

### Deservingness of Support

I usually finalized the interviews with the question: "In your view, why is it important to support farmworker communities?" As previously mentioned, the question's purpose was to explore the participants' reason for their involvement with farmworker communities, which allowed me to better understand their perceptions of farmworker health and identify any differences between the community stakeholders' perceptions. Ending the conversation on the importance of supporting farmworker communities also sparked hopeful calls-to-action, as all of the participants demonstrated a passion for their work in the community. In the final analysis, I observed that many participants referenced deservingness to explain their motivations for supporting farmworker communities. Through such reflections, participants revealed what they believed farmworkers deserve, expressed appreciation for farm work's value, and acknowledged



structural inequalities, lamenting how the general public often overlooks farmworkers' struggles. To better understand and contextualize participants' reflections, this section will apply scholars' theoretical concepts of deservingness.

Previous scholars have categorized numerous frames to describe perceptions of deservingness, some specifically focused on how people perceive undocumented immigrant populations' deservingness of health care (Bianchi, Oths, and White 2019; Melton 2015; Viladrich 2012). Such frames proved helpful in interpreting the participants' answers, although it is worth noting that not all farmworkers are undocumented immigrants. However, farmworkers do represent a "subpopulation of immigrants," due to the agriculture sector being dependent on immigrant labor "for more than a century" (Castañeda et al. 2015, 381; Wainer 2011, 2). Therefore, the frames proved adaptable to perceptions of farmworkers. For example, some participants stated that it is important to support farmworkers because they are human beings, therefore, applying the humanitarian frame to justify their view (Bianchi 2017, 60).

Essentially, the humanitarian frame of deservingness focuses on "assisting the suffering based on common humanity" (Bianchi 2017, 25). As an illustration, the following quote demonstrates WeCount! Nelson's application of the humanitarian frame:

"I think [supporting farmworkers] is important because farmworkers are human beings, and all of us deserve dignity and protection. Just because so many are hidden and invisible in farms and fields and camps and packing plants, doesn't make them any less deserving of robust government investment, of support, of security, of safety."

Comparatively, FWAF member Leonardo also expressed the need to protect farmworkers from structural injustice. However, Leonardo focused more on farmworkers' contribution to society than general human rights:

“[Supporting farmworkers is important] because food, they bring it to our table. And, if we don’t take care of them, eventually we’re not going to have anybody to do that for us. It would be great if we could each of us grow our own food, I think we would value more that work. But I don’t think that’s going to happen (chuckles). [We] just live in a too complex a world for—at least not overnight, but it would be great if we could have family or community gardens where every neighborhood each grows some food. But, until that happens, we need to make sure that the people who do grow our foods and bring it to our table are taken care of.”

Clinical instructor Leslie answered similarly, stating that, “Without [farmworkers], we have nothing.” At times, participants emphasized the value of farm work to justify why farmworkers deserve better treatment. For instance, clinical instructor Carla explained that it is in the federal government’s best interest to protect farmworkers because their work feeds the country. This argument, in part, mimics the “effortful immigrant frame,” which explains that immigrants deserve health benefits and protections because they usually “come to the United States for work and often take up employment with hard labor jobs” that most United States citizens avoid (Melton 2015, 2).

While the effortful immigrant frame is helpful in understanding how participants use farm work labor to justify workers’ deservingness, the frame fails to capture the community stakeholders’ deep appreciation for farmworkers’ labor (Melton 2015, 2). Notably, participants seemed to appreciate farmworkers’ labor with reverence; participants did not simply appreciate farmworkers for what farm labor contributed to them individually or to society. Rather, many were more keenly interested in making society compensate farmworkers for the immense value they produce, to hold farmworkers at a higher esteem, like the essential workers they are. For

example, notice how WeCount! Nelson expresses what farmworkers deserve while emphasizing their labor's value:

“Agriculture is one of the largest industries in the state of Florida, the labor of farmworkers is what allows us to eat, is what allows our kitchens to be stocked, our groceries to be stocked, our restaurants to have food supply. And without their labor, we would all go hungry essentially. And to recognize that this isn't about pity, it's not about pitying low-wage immigrant workers. It's actually about understanding their value, which is that they subsidize entire economies, that they're the ones who allow us to really survive and thrive. And, in a society that was truly just, that compensated and valued workers at the rate of the value that they produce, this society would be centering farmworkers for all the ways in which they contribute to our societal well-being.”

Many participants emphasized farm work's value when discussing the importance of supporting farmworkers but did not simply tie farmworker's intrinsic value to their economic worth. As shown above, they overlapped multiple frames of deservingness. For example, WeCount! Member Nelson overlapped the human rights and effortful immigrant frames to discuss why society should center farmworkers. Shortly after Nelson's quote above, he stated that it “doesn't matter what your job is, it doesn't matter how much you make, it doesn't matter if you have any income at all, it doesn't matter if you have status or don't have status,” essentially finalizing his thoughts by rejecting divisive narratives of deservingness and invoking a frame of equality for all. Clinical instructor Carla also overlapped multiple frames, as she employed the effortful immigrant frame above, then the “cost savings frame” to argue that providing access to farmworkers will prevent community members from paying non-insured patients' medical bills (Bianchi, Oths, and White 2019, 822). Carla then finalized her thoughts by

prioritizing farmworkers' lives rather than their economic contribution, stating, "Providing health care services to people who don't have access is an important thing so that we keep people healthy, and then people can continue to work and provide for their family, which is very important for our society."

Clinical research Dana also stated that farmworkers deserve support because "it's the decent thing to do and they're human just like us," applying the humanitarian frame (Bianchi 2017, 25). Additionally, Dana expressed how immigration status does not make you undeserving of care:

"If you are in this country, you are a contributing member of society of the economy of the workforce, of the culture. And so, you should have access to health care regardless of your immigration status because—communities suffer if one member is ill. [...] It affects us all."

Dana's statement includes multiple overlapping frames, as she partly invokes the effortful immigrant frame by referencing societal contributions, and then ends with the "public health as the ultimate goal" frame, which argues that everyone must be provided with health services because "doing so provides a public benefit" (Melton 2015, 2).

Overall, participants' perceptions on deservingness differed regardless of their occupations. Despite their differences in the use of deservingness frames, all participants recognized that farmworkers lack the protections and access that they need due to structural factors. This awareness of access barriers and structural shortcomings will be further explored in Chapter 5, in which I will present why community stakeholders perceive parallel health care systems as necessary. Furthermore, the next chapter will also compare and contrast the

participants' proposed solutions for bettering farmworker health outcomes and present the various ways they perceive two-tier health care.

## Chapter 5: Perceptions of Parallel Health Care Systems

Deborah has been involved with the Farmworker Association of Florida (FWAF) for more than 20 years. Her time with the organization began in 1995 after attending a program on farmworker justice organized by the FWAF and the Office for Farmworker Ministry (OFFM) that blew her away. “And [the experience] left an impression on me that I just started volunteering, and I just bugged them until they hired me. I wanted to work here so much, I actually begged to work here. I’m not going to leave until you hire me,” she laughed. Deborah shared her story with a glee that was so infectious, I often forgot our conversation was over the phone and that she could not see me grin in response. Before joining the FWAF, Deborah had been involved with social and environmental justice for years. In fact, it was Deborah’s work with another Florida non-profit organization (NGO) that required her to meet and collaborate with the farmworkers in the first place, sparking the experience that connected her to farmworker justice ever since. When asked to identify, in her view, what made witnessing the farmworker community so impactful, Deborah stated:

“I think that, to me, [farmworkers are] the core of everything. It’s a vortex where everything converges and out of which everything flows. Because, at its very most basic, every person on the planet has to eat, and it can’t get more basic than that. [...] So, it’s extremely basic and, yet the people that harvest the food are unrecognized, unappreciated, uncompensated and discriminated against. And the poor wages, horrible housing—and they sometimes live very difficult, challenging lives—and low life expectancies. And so, to me it was, ‘how can we have a system in which the people that do some of the most important work in the world, keeping the rest of us alive by feeding us, can be treated so badly.’”

In essence, Deborah embodied farmworker activism after learning of the ways farmworkers are systematically marginalized. Although every participants' initial introductions to the cause are unique, they all generally shared Deborah's intolerance for systemic marginalization. This shared perception connected them as a network of community stakeholders, who came together to create accessible pathways to health care through free health clinics, farmworker health research, and free COVID-19 testing.

Notably, such efforts may result in a parallel health care system. That is to say, a shadow health care system that relies on fragmented funding sources and volunteers to provide care to populations lacking the necessary insurance, socioeconomic status, or legal documentation to benefit from the public medical system (Portes, Light, and Fernández-Kelly 2009). The existence of parallel health care systems implies that the United States' health care structure is divided into two separate tiers, each operating for different populations with differing socioeconomic and legal statuses (Castañeda 2010, 12). While researchers have previously studied parallel and two-tiered health care systems within immigrant communities before (Castañeda 2010; Kline 2017; Biswas et al. 2011; Sigvardsdotter 2012), and also investigated community stakeholders' perceptions on the matter (Dauvrin et al. 2019; Harthorn 1998), more research is needed to understand parallel medical systems within farmworker communities through the perspectives of its stakeholders.

The following section will consider why the free health clinic hosted by the FWAF and other examples of shadow systems of aid emerged as a parallel health care system within the Florida farmworker community. To understand the 'why' of the emergence, I identified which structural shortcomings participants cited the most to explain why parallel systems are needed. In essence, participants usually cited farmworkers' social abandonment to explain the emergence of

parallel health care systems (Biehl 2005). In the second section, I then integrated the community stakeholders' emerging interpretations of the parallel or two-tiered health care concepts with previous scholars' findings. This way, I compared and contrasted the participants' lived experiences of parallel medical systems to their corresponding academic description; this analysis not only evaluated how the participants perceived these concepts in their day-to-day life, but also expanded previous scholars' arguments with more ethnographic data. In the final third section, I present the community stakeholders' proposed solutions for the multiple issues they have described. Although the participants proposed different solutions to substitute the current parallel health care system, they shared a preference for some sort of structural reform rather than intervening on individual farmworker behavior.

*Social Abandonment: The Emergence of Parallel Health Care Systems*

Of course, every participants' introductions to, and reasons for, participating in farmworker advocacy and volunteerism are unique to them. However, a common thread throughout participant interviews is their acknowledgment of government policies and the public health care system's structural shortcomings. This thread, or pattern, ultimately reveals that this participant network is connected by a shared "fundamental rejection of political discourses and government policies," which treat (un)documented farmworkers' health as unworthy of concern (Willen 2011, 305; as cited in Bianchi 2017, 60). That is to say, a fundamental rejection of the state-sanctioned idea that farmworkers are unworthy, or undeserving, of care, is what drives this participant network to pool together the resources and collaborations needed to provide farmworkers with informal primary care. The participants explained why informal or parallel health care systems are necessary through structural explanatory factors, such as the policies, or a lack thereof, that ignore farmworkers and leave them behind. Through this view, participants



perceived parallel health care systems or aid systems as needed to fill in the gaps left open by lack of government attention or support. Learning about how or why parallel health care systems emerge at the local level, especially from the perspective of its contributors, also helps us understand and concretize the effects of structural inequality.

As mentioned above, participants discussed how government policies ignore farmworker communities' needs and exclude them from public benefits, causing farmworkers to depend on parallel health care systems. This particular perception closely resembles Biehl's (2005) theoretical concept of "zones of social abandonment," which describes places that are lacking much-needed medical and governmental attention (Selimović 2006, 300). Some of the perceived aspects of social abandonment within farmworker communities included hurtful policies that excluded poor or unauthorized, or both, farmworkers from accessing health care; persistent government neglect during the COVID-19 pandemic; and a historical lack of policies protecting farmworkers from workplace abuses (Biehl 2005).

For some of the health care practitioners who were not entirely exposed to farmworkers' health struggles, the lack of health care access and government support in farmworker communities shocked them. Clinical instructor Leslie exemplified this in her description of the FWAF free clinic's first night in 2016:

"Well, [the clinic] is growing beyond anything we could have possibly imagined because we thought, maybe—and it was funny, the very first day that we did it, [we thought we] might see 25 to 30 patients, we had no idea. And the first night 83 people came, and we thought: 'Huh, I think this community needs more than what we even imagined.'"

Now, the FWAF free clinic has provided care to about 1,500 patients in the last four years. Clinical instructor Carla also experienced shock when learning about the lack of health care

access in farmworker communities, especially when confronted by the restrictive policies of Federally Qualified Health Clinics. To illustrate this, here is her answer when asked what surprised her about the amount of need she witnessed:

“I’ve been a [health care practitioner] for like 20 some odd years. Whether people not having a primary care doctor for basic things, [...] when you ask them when was the last time you went to a doctor, and sometimes they can’t even remember when was the last time that they saw a doctor. So, I think that was what shocked me [...] the fact that they did not have access, that there are some community organizations that are in that community, but if you’re undocumented, you do not have access to them. So, that I think that was the biggest shocker to me because, as a [health care practitioner], I don’t care about your status, that’s not my—I don’t care who you are.”

Through these discussions, both health care professionals showcased their awareness of the need in farmworker communities. It is noteworthy that clinical instructor Carla bridged her awareness of restrictive policies and that she expressed a clear rejection of such policies that turn anyone away, as this connects her perception to the rest of the participants’ who reject the same.

Indeed, Carla’s observation of Federally Qualified Health Clinics serves as an example of the type of restrictive policies that overlook immigrant farmworkers and cause them to seek informal health care sites elsewhere. Even though Federally Qualified Health Clinics are legally mandated to see everyone, their requirements for proof of residence and income are extremely out of touch with many immigrant workers’ reality (Portes, Light, and Fernández-Kelly 2009, 10). Some of the communities most in need are “employed in informal jobs, racing from one place of work to another, and living six to an apartment, can scarcely produce income tax forms or six months of utility bills” (Portes, Light, and Fernández-Kelly 2009, 10). Yet, government

policies do not consider such factors, resulting in policy “solutions” that disenfranchise and abandon the very communities they are designed to help.

Considering that health care inequalities and government inattention have troubled farmworker communities for decades, the COVID-19 pandemic only further emphasized the health disparities within this particular workforce. For example, many participants perceived the COVID-19 pandemic as clearly exposing the social abandonment that farmworker communities face. Clinical instructor Dana specifically observed a noticeable absence of culturally appropriate COVID-19 education initiatives within farmworker communities.

“And for some—they don't even know how to get COVID-19 testing. Is it even real? I've heard them say for example, that if you get tested you'll get COVID-19 or that it's a hoax. [There is] a lot of disinformation in the community and partly because there hasn't been this public initiative from public health to go into the farmworker community, our essential workforce, and provide those protections and information and testing in a way that is culturally appropriate within the farmworker community.”

According to Dana, the COVID-19 pandemic has heightened the inequalities that exist within farmworker communities. On top of farmworker communities' health disparities and lack of health care access, farmworkers may even question if COVID-19 is a real threat and avoid testing or vaccination. For Dana, the blame falls on the public health system, which has not invested the necessary time and resources to include farmworkers into COVID-19 education initiatives.

FWAF member Leonardo also explained how the COVID-19 pandemic exacerbated existing inequalities, this time by highlighting rural communities' lack of access to quality foods:

“When the pandemic broke out and everybody started getting food, a lot of farmworkers were sort of left in the dust with empty shells in the local stores. And then the supply line had been restored or replenished, but [...] it became really apparent, the inadequacies of our food system, where we were leaving a lot of people behind. Not just farmworkers, but all kinds of working people.”

Leonardo’s statement refers to the way that farmworker neighborhoods, most of them localized in rural locations, frequently exist within “food deserts” where access to quality and affordable foods is limited (National Research Council 2015, 200). Reyes (2012) considered farmworker neighborhoods as possible zones of social abandonment, as the areas are often riddled with social problems due to being “remote, isolated, or underserved neighborhoods” (Reyes 2012, 74; Marsh et al. 2015, 325). For instance, apart from lacking access to quality foods, farmworker neighborhoods also face difficulties with reaching health care providers due to their remoteness and underserved state (i.e., lacking a balanced ratio of primary care physicians per 1,000 people) (Marsh et al. 2015, 326; Segen’s Medical Dictionary 2021). Multiple participants, such as FWAF member Deborah, agreed that farmworkers in rural neighborhoods struggle with accessing health care:

“So, access to health care is a really big problem, a lot of them live in really remote rural areas. Getting to a clinic, or someplace where they can get health care, can be really difficult, [as] a lot of them live in rural areas or don’t have transportation to get there. [Redacted] [spoke of] one time having to walk 30 miles [to] get health care for herself and her baby.”

Because farmworker communities often lack medical and governmental attention, organizations like FWAF and WeCount! turn to onsite volunteer-driven clinics in order to provide

farmworkers with care in an accessible environment (Selimović 2006, 300). Here, it is possible to see how the participants' perception of farmworkers as socially abandoned by their government leads to the emergence of parallel health care systems.

The purpose of partnering with health care providers to organize onsite clinics is, as WeCount! member Nelson describes, for “farmworkers and other low-wage immigrant workers to have a place where they can go that’s safe and trusted. Where they can then access primary care, health and wellness screenings and other kinds of medical services, either for free or sliding scale.” The Farmworker Association of Florida (FWAF) also collaborates with different universities and organizations to help farmworkers access health care in spite of the government’s absence. Here is FWAF member Leonardo’s description of this collaboration:

“So, [Redacted University] comes out and we provide the facilities and [Redacted University] provides some medical help. Oftentimes it’s not a substitute for long-term care, but, at least, it can be a good way of getting workers to check for the minimum of health problems that they might have.”

WeCount! member Nelson similarly acknowledged that these solutions are insufficient, stating that “[non-profit organizations] will never have the resources or the infrastructure to meaningfully fill that gap.” While the majority of participants recognized better and more transformative solutions aside from organizing parallel medical or aid systems to problem solve, many were still grateful for the opportunity to help. Like FWAF member Leonardo said, volunteer-driven clinics are at least providing farmworkers with a level of primary care. Additionally, the clinical instructors were both vocal of their gratitude, such as Carla who highlighted the entirety of her time working at the FWAF free health clinic as special:

“I think it’s just the whole fact that we’re able to do something like this is phenomenal, the fact that we’re able to sticks with me every time. I would say the first time was probably the most emotional time. Because—oh my gosh—cause there's a lot of planning, there’s a lot of collaboration that occurs, you have to build trust, and the fact that it actually came to life...that was I would say the most important— [...] the actual start.”

Participants also discussed how anti-immigration laws caused farmworkers to be excluded from government support; this exclusion forced communities to form financial parallel systems in order to help farmworkers during the pandemic. For example, WeCount! member Nelson explained how his organization had to circumvent immigrant workers’ exclusion from pandemic relief:

“[...] One of the things that we realized early on during COVID-19 was that a lot of the federal programs, like the CARES acts, the federal stimulus, all excluded undocumented workers. So, we decided at WeCount! to create an immigrant worker COVID-19 fund. It’s a mutual aid fund where we provided direct financial relief to undocumented workers.”

In this case, WeCount! created the mutual aid fund due to the government’s lack of support towards undocumented immigrant workers in the United States. And considering that about “half of all United States’ hired farmworkers are unauthorized immigrants,” the government’s anti-immigration policies truly excluded a large portion of the farmworker community from receiving aid during a nation-wide emergency (Wainer 2011, 1). Participants, like clinical researcher Dana, pointed out how contradictory it is for the government to identify farmworkers as an essential workforce yet still exclude them from stimulus aid.

As shown above, participants perceived parallel health care and financial aid systems as necessary to fill in the gaps left open by the government's lack of support. Clinical instructor Carla, in particular, highlighted local organizations' key role in counteracting social abandonment, especially during the pandemic:

“Local organizations are so important because they are able to help some communities that do not have access to, quote-unquote, the public community services. They bridge the gap, like [...] they're a bridge for people who don't have access to other organizations, so it's almost like a safety-net? And I think now, even more than ever, that those organizations are needed even more. Because there are some people who will not have access to food stamps, who will not have access to certain things because of their documentation status. So, food banks, churches, these grass roots organizations, those are the organizations that are able to work and help some of the people that are on the fringes of our society.”

Parallel systems formed by local organizations are not always created to provide health care services, but general financial and resource needs as well, as can be seen from WeCount! and Carla's examples. Although mutual aid funds and food banks differ from the definition of parallel health care systems, these acts are caused by the same issues that, according to the participants, cause parallel health systems to emerge: a lack of government support and attention.

Another example of social abandonment is the lack of farmworker protective policies. In detail, clinical researcher Dana stated that the government does not enforce necessary farmworker labor protections, such as federal heat protection standards. “So that leaves two to three million agricultural workers vulnerable,” explained Dana. For Dana, the lack of protective policies creates just as much vulnerability as punitive immigration policies. Anthropologists

Poole and Riggan (2020), and Holmes (2013), hold a similar view, as they argue, “Violence not only involves direct acts of harm, but also the ways in which social systems and institutions and can produce suffering and harm by failing to meet basic needs” (415).

Dana’s observation of the absent critical policy protections regarding farmworkers correlates with the history of labor laws. Indeed, agricultural labor forces are one of “the least protected workers in America” (Bauer and Ramírez 2010, 29). Because people of color have historically performed farm work, major federal labor laws passed in the 1930s’ New Deal Era specifically excluded farmworkers protections “to preserve the social and racial order” on which the United States’ agricultural industry depended (Bauer and Ramírez 2010, 30). That is to say, farmworker exploitation is ingrained within the United States’ agricultural system and legitimized through a lack of protective policy. As a result of this racially charged exclusion, many farmworkers are currently ineligible for workers’ compensation, overtime pay, or general labor benefits; farmworkers are also excluded from state health and safety laws, and the National Labor Relations Act, meaning they are not protected against unfair labor practices (Bauer and Ramírez 2010, 30; Bermudez 2012, 8).

As can be seen, the act of excluding, or socially abandoning, farmworkers may be an intentional one in the United States. FWAF member Leonardo acknowledged the intentionality behind the agricultural system’s neglect before: “The system is set up so we have a pool of cheap labor, and so we need that pool of cheap labor, and for it to be cheap, it has to be desperate.” Some scholars, such as Agamben (2005) and De León (2015), have theorized that sovereign authorities are able to mistreat certain populations, such as undocumented immigrants, by claiming a “state of exception.” Basically, a state of exception is the process through which sovereign authorities are able to waive a specific population’s rights to legal and moral



protections; however, sovereign authorities are still able to punish these populations through the nation's laws (Agamben 2005; De León 2015, 27). So, through this concept, farmworkers are understood as “in the nation,” since they can be punished by immigration policies, “but not part of the nation,” as government policies either exclude them from legal citizenship or bar them from common federal labor protections (Gonzales and Chavez 2012, 257).

Sovereign authorities can bypass public uproar by justifying their claim as done in the service of the public (De León 2015, 27). As FWAF member Leonardo said, the agricultural system requires a pool of cheap labor to provide consumers with a service: cheaper products (Martin 2003). That, unfortunately, is “the high costs of cheap food,” as author Slongwhite (2014) would say. Overall, such justified states of exception cause farmworker communities to be excluded from public benefits and, ultimately, socially abandoned (Biehl 2005; Agamben 2005). However, grassroots organizations such as FWAF and WeCount!, plus their network of volunteer health care providers, come together through their shared rejection of such mistreatment. Their rejection, as a result, is embodied through the multiple parallel systems they organize to provide farmworkers with accessible care; immigrant worker mutual aid funds, onsite COVID-19 testing stations, and free health care clinics held four times a year, are but a few examples of such efforts.

#### *Emerging Interpretations of Parallel or Two-Tiered Health Care Systems*

This community stakeholder network's general perception is that structural gaps, left open by lack of government support or attention, ultimately led to farmworkers' basic needs being unmet. And, although most participants acknowledged that parallel health care systems are not efficient long-term solutions to such gaps, many expressed gratitude at the chance of providing farmworkers with at least some type of health care access and financial relief through

their collaborative efforts. With that said, previous scholars have theorized about the potential implications that parallel health care systems provide about larger structural factors. For instance, scholars theorize that inequality forces parallel medical systems to emerge, and that their existence divides the health care system into two distinct tiers (Castañeda 2010, 10). Thus, I asked the participants to think about the topics of parallel or two-tiered health care systems and the role of the federal government, to connect their experiences to the observations of previous scholars. Furthermore, their discussions allowed me to answer the final research question, which inquired about community stakeholders' perceptions of parallel or two-tiered health care systems. Altogether, participants agreed that they perceived a division of health care and persistent inequality; however, some perceived two distinct tiers, while others saw the term "tiers" as too clear-cut to explain the health care system's complexity.

Previous scholars have proposed that the existence of parallel or two-tiered medical systems implies specific characteristics of large social structures like the United States' health care system. Castañeda (2010) specifically argued that parallel health care systems only emerge when health care inequality exists; indeed, Castañeda (2010) states that the existence of parallel systems only further asserts that the United States' health care structure is accustomed to inequality (12). Likewise, Biswas et al. (2011) suggest that governments may pass on their duty to ensure equal access to health care by delegating such duties to parallel health care systems organized by communities (10). From the earliest formulations of this thesis, I set out to investigate community stakeholders' perceptions of such implications with the hopes of integrating local stakeholders' own descriptions of parallel and two-tiered health care systems into the existing literature.

I opened up the discussion by describing the concept of a two-tiered health care system. I described the system as two distinct tiers of health care, each with differing quality and accessible to differing populations, mentioned how punitive immigration policies may cause them to emerge, and suggested that such system's existence may imply that the government relinquishes their responsibility to protect the underserved. Then, I asked if they agreed or disagreed with this description or if they have observed a similar phenomenon. For FWAF member Leonardo, my description prompted some pause. "Well, first of all, this is the first time [I've heard] the health care system described that way," he began, "but, it sounds accurate. I feel like definitely there are two systems of health care, one for those who can afford it and one for those who cannot."

Leonardo's description is validated by previous research, which indicates that the usage of health care services differs by income groups (as cited in Alves and Timmins 2003, 11). That is to say, a person's income is an indicator of their ability to access health care, and the quality of such care. Clinical researcher Dana's response to my description similarly integrated the role of socioeconomic status, and she compared it to the education system's excluding nature:

"I think [the description] is accurate. I had also heard it described as modern-day segregation. There's the health care for those that can afford it, have access to it, and then for others who cannot—we see it in education too right? Some people can afford to go to college, others cannot. We see it with undocumented or DACA students, who have all of these barriers to try to go to college. And, in some state, they're banned from going to colleges and receiving in-state tuition. It's modern-day segregation."

Although Dana mentions the punitive quality of anti-immigration laws, she does not center this when describing the health care system's segregative character; rather the focus revolves around

multiple factors, including socioeconomic status. Other participants also highlighted socioeconomic status as a major social factor determining access to health care. For example, FWAF member Deborah states that the existence of two-tiered health care systems in the United States goes “beyond just immigrants,” as the division is due to a lack of universal or affordable health care. Clinical instructor Carla approached the concept of two-tiered health care a bit differently, as she especially emphasized low socioeconomic status as the main factor barring populations from accessing health care:

“In my practice as a [health care practitioner]—I have had people who are born and raised here who don't have access to health care, [because] they can't afford it. So, sometimes I don't think it has just to do with documentation, I think it has a lot to do with socioeconomics, plain and simple, period. Because I also worked in Miami, where I've seen affluent Hispanic people like, fly in on a private jet, and pay out of pocket for health care services. So, I think it has a lot to do with socioeconomics, but it's harder for undocumented but—if you have the money you can—you have access. [...] If you have the money, you can pay for it. No one's going to stop you, you'll find somebody. [...] I've been in health care for a long time, so I've seen it to where it's not just whether you're black or white or Hispanic, or documented versus undocumented, farmworker versus not, it really has to do with money. At the end of the day all the conversation is about money.”

These answers represent a pattern in perception, in which socioeconomic status is generally perceived as either bearing the most, or a good amount, of weight when considering factors barring health care accessibility. FWAF member Deborah's discussions on the compound social factors that deter farmworkers from accessing health care shed some light on why this pattern appears.

FWAF member Deborah asserts her belief that immigrants are the population most affected by the United States' lack of affordable or accessible health care; but, to her, anti-immigration policies are not the only reason at the core of this structural issue. Instead, Deborah believes that the "major problem" is the United States' systemic marginalization of minority communities and a lack of universal health care. To showcase this, FWAF member Deborah describes the variety of situations she witnesses at the FWAF organization:

"We have farmworkers come here and—again, I think that immigrants get the worst brunt of it, but you don't have to be an immigrant, minorities who are low-income are also—we work with the black population too and a lot of them have similar problems. They don't have health insurance from their work. And so, they might have more access to Medicaid or systems, but a lot of them fall through the cracks too."

Regardless of immigration status, farmworkers are generally less likely to have health insurance, and more likely to have a family income below the poverty level than the overall population (as cited in Reid and Schenker 2016, 645). Such patterns showcase that immigration status is one of the many social determinants that are actively barring farmworkers from interacting with the public health care system. Thus, it makes sense for FWAF member Deborah to expand my original description of two-tiered health care (which only focused on immigration policies' role) by discussing how socioeconomic status, documentation, and structural shortcomings compound to bar farmworkers' health care access. With that said, Deborah finished her point by re-stating the importance of including unauthorized immigrant within the health care structure:

"If you're undocumented, you can't really apply for the Affordable Care Act. So, that's an issue too, [that] really puts undocumented immigrants at a huge disadvantage. So, they

have to rely on local community clinics. And then [local community clinics] are always struggling for funding. So yeah, there is definitely a two-tiered system.”

Deborah’s statement is noteworthy, as it connects the existence of unequal access to care (i.e., undocumented farmworkers cannot apply for insurance) as the cause of parallel or two-tiered health care systems’ emergence (i.e., over-reliance on local community clinics). This connection showcases that some community stakeholders, who are experiencing these theories and concepts on the ground, continue to perceive inequality as the root cause of poor health outcomes and unequal access; this perception mirrors Castañeda’s (2010) arguments of inequality being the force behind the “widespread reliance on charity clinics, volunteerism, and humanitarianism” (13).

Another important point in Deborah’s statement is her acknowledgment of parallel medical systems’ funding limitations. Funding limitations further amplify the health disparities that arise from, as Castañeda (2010) would say, a health care system accustomed to inequality; this is because parallel health care systems’ level of care is unequal to formalized levels of care (12). Portes, Light, and Fernández-Kelly (2009) assert that granting health care with “no questions asked and no billing later” is an expensive feat in the United States, which leaves these clinics with limited levels of care for underserved populations (14). Echoing the literature’s stance on parallel health care’s disadvantages, WeCount! member Nelson states that non-profit organizations will “never have the resources or the infrastructure to fill meaningfully in that gap,” left open by the federal government’s lack of universal coverage and support (Portes, Light, and Fernández-Kelly 2009, 14).

The issue of philanthropic medicine’s inefficient power and resources leads us back to the question of the federal government’s responsibility in delivering care to underserved

populations. Could the federal government be relegating their responsibility of providing health care to community-organized parallel medical systems, as Biswas et al. (2011) suggest? For FWAF member Leonardo, the federal government's support is noticeably absent and accountability from their part is needed:

“I think definitely we should hold the [United States] accountable and responsible for that whole class of people who are being left without access to health care, who have to fend for themselves, and are unable to [do so].”

Furthermore, WeCount! member Nelson offered his view on the government's role within immigrant health provision. Although Nelson's insight does not entirely suggest that the federal government is consciously depending on parallel systems to avoid accountability, his observations are still valuable. For example, Nelson believes that the state has either abdicated or consciously minimized their role in providing equal support to populations, forcing local communities to “step into that gap”:

“[The pandemic] has made it very clear, [...] that the role of the state, the role of government is minimized. Things that the government should be taking care of, the common good—things like education, like health care, like jobs—are things that the government should play an active role, in making sure that standards are high, people are protected. Unfortunately, we see an attempt to minimize the role of the state through privatization, through all these mechanisms that defund or disconnect the state from critical programs, critical benefits, and critical support. And in that gap, nonprofits, and even like informal volunteer associations, and even neighbors and friends and family members have to find the resiliency to step into that gap and problem solve.”

Multiple factors may lead the federal government to abdicate their role in providing aid or health care delivery to certain population in the nation, a question which rests beyond this study's research scope. With that said, previous research on parallel health care systems and its community stakeholders has highlighted how conservative political ideology persuades governments into dismissing their responsibility of providing for unauthorized or low-income populations (Portes, Light, and Fernández-Kelly 2009, 14). Nevertheless, it is important to note that Nelson perceives the federal government as holding such a minimal role in the efforts to support immigrant workers, that local communities feel the need to step in. Thus, Castañeda's (2010) assertion that parallel systems emerge from persistence inequality is validated by not only Nelson's perceptions, but other participants as well, who agree that the health care system has structural gaps.

So far, I have presented participants' answers that showcase a general consensus and correlate with previous scholars' observations. Namely, most participants highlighted socioeconomic status as highly influential when considering farmworkers' access to care. At the same time, participants' perceptions of structural inequality and government inactivity matched some of the arguments proposed in the two-tiered health care literature, which further enriches these scholars' observations. However, some participants challenged the idea that the United States' health care system, with all its complexities, could be boiled down to the concept of two distinct tiers. FWA member Leonardo notably added the concept of "chutes and ladders" onto the two-tiered health care concept:

"I guess I'm thinking of [Redacted University] who has like this top of the line, world renowned hospital, but they also work with us to make some of that health care accessible. So, I think that it's not just a two-tiered system, I think there are several



layers. I guess it might be like a two-tiered system but [...] each tier has its chutes and ladders. Because I think that there are people who work in for-profit health care systems who also take some of their personal time—or who sometimes they may be [at] for-profit health care systems and then join Doctors Without Borders, or another organization like that. So, I'm not excusing that, I don't think it's ideal. I think it's a little more complicated than two tiers.”

Leonardo's description refers to the collaborative nature of grassroots organization members and health care practitioners within the second tier of volunteer informal care; his musings also bear some resemblance to Sigvardsson's (2012) observations of two-tiered health care systems. Just as Leonardo points out how health care professionals move back and forth between different interacting tiers of health care, Sigvardsson (2012) describes how Swedish health care professionals take on “dual identities,” as they work at formal hospitals by day, and treat undocumented immigrants by night (97).

The borders between “formal” health care (i.e., for-profit hospitals) and “informal” parallel health care (i.e., free local clinics) are porous, constantly penetrated and crossed by health care professionals with enough time to keep up with their formal responsibilities and volunteer their services (Sigvardsson 2012, 96). So, FWAF member Leonardo is right to problematize a concept that attempts to organize the United States' health care system, when in between such “tiers” exist complex dualities of identity, as Sigvardsson (2012) suggests. Simultaneously, between such “tiers” are also compounding social factors that differently determine one's access to health care, like documentation and socioeconomic status, employment, housing location, transportation, and so forth. For this reason, clinical instructor

Carla hesitated to claim that the United States' health care system is divided into two distinct tiers because of anti-immigration policies:

“Well, as far as health care is concerned, it's a hot mess—excuse my French—for regular old everybody. I think health care is a complicated—it's not very black and white, I can't really say it's either one way or the other because you have American people who don't have access to health care, so it's complicated.”

In summary, introducing the parallel or two-tiered health care concept into these interviews allowed participants to vocalize their interpretations of such concepts. For many, the different tiers were understood as those who can afford health care versus those who cannot, centering socioeconomic status as an influential factor among other determinants. For others, the term “tier” may not truly capture the complexity of the health care system. Regardless, the majority of participants perceived structural inequality as cause for parallel medical systems' rise and lamented the federal government's absence in providing the necessary support and infrastructure to populations of low-income or undocumented status, or both. Such perceptions complement the existing literature's previous observations of parallel or two-tiered health care systems around the world.

### *Proposed Solutions*

In between discussions of social abandonment (Biehl 2005), two-tiered health care systems (Castañeda 2010), and the federal government's responsibility toward farmworker communities, many participants discussed their ideal solutions to help reform the structural inequalities affecting farmworkers in the United States. From discussions of reforming the United States' health care structure, to supporting farmworkers in their journey of self-advocacy,

I compared and contrasted participants' proposed solutions to better understand the differences between both community stakeholder groups' perceptions of solutions.

To start, universal health care was the participants' most commonly recommended solution for aiding farmworkers. The current health insurance system supported by the United States enables a "tiered and sometimes racially segregated" health care system, thus, further emphasizing farmworkers' poor health outcomes and lack of health care access (Yearby and Mohapatra 2021, 42). Participants then advocated for a universal single-payer health care system, which is usually funded by the government and offered to residents free of charge (Yu and Zhang 2017, 818). Clinical instructor Leslie believed in all the positives that universal health care might offer, and rejected how the current system prioritizes money over providing care:

"There shouldn't just be health care for farmworkers, there should be health care for all of us. [...] Health care is so ridiculously expensive. One cancer diagnosis can bankrupt a normal middle-class family. Imagine what that would do to the underserved of any sort, and that's just not fair, that's not the way we want to treat people."

For WeCount! member Nelson, health care is a human right, but he recognizes that accepting and implementing that sort of belief within policies is an ongoing struggle across the world:

"We ground so much of our political principles on the values of human rights, there are things that are fundamental to people, regardless of their position, role, or identity. And things like migration as a human right. But another one of those is health, and health care as a fundamental human right that all people deserve regardless of their immigration status. And so, what I think [WeCount!] wants and believes in, which I think is an ongoing process of struggle in this country and across the world, is that all people,

farmworker and non-farmworker alike, should have access to high-quality, government guaranteed health care...Medicare for all, essentially.”

Universal health care was a popular solution among participants, as moving away from any “tiered” system would “ensure more equitable care,” according to Yearby and Mohapatra (2021) (42). However, FWAF member Leonardo hesitated to fully agree with the idea of the federal government acting as the sole health care provider for all, including farmworkers. For Leonardo, his reticence arose from an acknowledgment of what might be lost in the process:

“My reticence to a blanket statement like telling the United States to cover all farmworkers is that there is a lot of traditional health care knowledge that has been passed down through generations...Little home remedies like teas and medicinal plants, or ointments to put on your skin to alleviate some pain, all those things are not without their merit and I think if we rely on a single—not against a single-payer system, I think that would be great—but, I think we should also allow for some sharing of that knowledge that traditional communities bring with them.”

Leonardo’s observation centers the farmworker community by considering how their various cultural practices, beliefs, and attitudes shape their interpretation of health care. WeCount! member Nelson took a similar approach by advocating for structural solutions that are planned, led, and achieved by self-advocating farmworkers. Notably, Nelson’s perception arises from his affiliated organization’s ultimate end, which he describes as: “to make sure that our social, economic, and political systems don’t just take into account the needs of workers and migrants, but that [these same systems] are shaped directly by workers and migrants.” For Nelson, any structural reform that does not grant immigrant workers “social, economic, and political power” may not be considered a real fix:

“Our approach to community service is to understand that we are not simply here to replicate charity models of service, to try to stop some of the flaws or gaps that exist within existing government systems, and government programs. But that our role is really to transform those systems and to help make sure that low-wage immigrant workers are actively shaping policies at a local and state level that directly benefit them.”

In essence, Nelson’s community service approach similarly mirrors Swedish service organizations’ methods, which involve “working toward their own abolition—a situation where undocumented persons can access public health care and they won’t be needed anymore, but in the meantime, they fill the gap in which undocumented persons fall” (Sigvardsson 2012, 95). As social justice organizations, both WeCount! and the FWAFF echo Sigvardsson’s (2012) description.

Participants also highlighted immigration reform, among other possible solutions to significantly help undocumented farmworkers. For FWAFF member Deborah, “Huge structural reform” across the board represents the ideal long-term solution to help farmworkers in the United States. Deborah’s important systematic transformations included “justice in the entire food system, adequate pay, education, housing,” and nationwide immigration reform. Likewise, clinical researcher Dana emphasized policies, such as punitive immigration policies, as the drivers behind social determinants of health. Thus, for Dana, the most impactful solutions include legalizing undocumented immigrants:

“Once you have the authorization to be working in the [United States] legally, a green card, then you have a voice to say if there’s an injustice happening at work, to be able to have push for policy changes. When you are undocumented, you are kind of handcuffed by that because there’s this fear of retaliation, deportation, that’s there. I’m sure you’ve

seen news where they talk about ‘someone went to the hospital and a health care provider called immigration and they were taken away.’ Living undocumented contributes to health and if we could fix that, we could fix many other things.”

Castañeda et al. (2015) similarly argue that undocumented status impact immigrants’ access to health protective services and constrain individual choice, overall impacting immigrant health outcomes. Immigration reform played a role within clinical instructor Leslie’s proposed solution, among statements on the unfair treatment of farmworkers in general:

“I mean these farmworkers, if we didn’t have them, there would not be food on our tables. So, why are they not being paid a wage that’s worth them living? Why are they considered illegal? They’re not [illegal]. And a lot of them were on Visas, but they’re so scared because maybe the husband in on a Visa but the wife isn’t. But why isn’t that something that we take care of? Otherwise what is our country going to be? There will be no food.”

For Leslie, social justice advocacy, organized by groups like the FWAF or WeCount!, is necessary to ensure that farmworkers’ basic needs are met on a structural level.

Lastly, clinical instructor Carla revolved her proposed solution around the need for accessible primary care that correlates with specific farmworker needs. For example, Carla considered how changing the usual health clinic’s nine-to-five structure to a five-to-nine schedule could benefit late-working farmworkers; to achieve this, Carla recommended the idea of nurse-run clinics:

“Nurses can fill the gap [...] by providing the primary care that they need. Maybe like a nurse-run clinic that people would have access to, but that would dream too in the future, that we can have maybe a nurse-run clinic to fill that gap of primary care. [...] Maybe the

health care structure is five-to-nine, where people could get off work and go to the clinic. Because there are methods to help, and then even if people don't have insurance they could have a sliding-scale fee, like they pay a certain amount of money for blood tests, but at least they would have access.”

Overall, I concluded that, while they all geared their solutions toward structural reform rather than individual interventions, some explicitly centered farmworkers as self-advocates within their solutions.

## Chapter 6: Conclusion

This study aimed to understand the perceptions of farmworker health and parallel health care systems emerging in community stakeholder networks. Throughout this study, I argue that this community stakeholder network generally perceives farmworker health issues as largely impacted by structural factors. As presented, the participants relied on structural explanatory factors, such as the social determinants of health, to discuss how workplace policies, immigration policies, and socioeconomic status inform and shape farmworker health and behaviors. Furthermore, participants explained the emergence of parallel health care systems, organized through volunteerism and humanitarianism, as caused by health inequality and the governments' lack of structural support toward farmworker communities in Florida. Considering Castañeda et al.'s (2015) im/migrant health frameworks, the participants' focus on social factors that exist externally from farmworkers' bodies classifies their perceptions as fitting the structural framework (380).

Comparing and contrasting such perceptions then allowed me an in-depth look into the ambiguities, variances, and similarities embedded in the participants' answers. Looking into the perceptions' different dimensions allowed me to analyze a rich ethnographic data set full of "new yet relevant topics" (O'Reilly 2012, 121). For instance, conversations of agency, resiliency, and victimization arose from questions of term usage, and differing frames of perceptions were revealed when the participants and I discussed why farmworkers deserved support. Additionally, participants' proposed solutions shared elements of structural reform, yet also covered a breadth of different possibilities, venturing from universal health care to the power of farmworker self-advocacy. Overall, participants' reflections on farmworker communities led me to conclude that having a specific occupation type (i.e., grassroots organization member or health care



practitioner) could not predict the participants' perceptions; members from the same occupation routinely contradicted each other and brought forth diverse perceptions of farmworker issues, many times in ways which wholly enriched the data set.

Finally, this study's participant network holds relevant positions within the farmworker community, as they all directly or indirectly interact with one another to organize accessible health care systems for farmworkers. As a result, their experiences within parallel health care systems hold valuable information about the large-scale social structures that cause an over-reliance on informal health clinics. For this reason, I intertwined participants' interpretations of parallel or two-tiered health care concepts with the existing literature observations to both contextualize participants' perceptions and contribute to the topic's ever-growing ethnographic data set. Altogether, my analysis concluded that the community stakeholders simultaneously agreed with the existence of a two-tiered health care system because of their hyperawareness of structural inequality yet disagreed with the concept's attempt to structure a highly complex health care system. Prevalent within each sub-section was the participants' mindfulness of structural inequality, which they vocally identified as the root cause of farmworker struggles.

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