This paper examines limitations and challenges in health service provision for migrant laborers in the United States (U.S.). Specific focus areas within this broad topic discussed in this paper include health service needs; gaps or deficiencies in health service access; strategies that have been developed to address these deficiencies; and cultural frameworks regarding the perceived 'deservingness' of undocumented immigrants for access to health services. In the context of health service provision, 'access' is defined herein as 'the timely use of personal health services to achieve best possible health outcomes' (De Jesus and Xiao, 2012).

For immigrant communities overall, limitations on access to health services can result from factors including documentation status, cultural and language barriers, the political and social environment of the country in which immigrants are attempting to work (Moyce and Schenker, 2018), and within the U.S., lack of access to health insurance. Within the U.S., and specifically within the context of migrant labor, the access gap in health service provision may be the most critical for the Hispanic population (De Jesus and Xiao, 2012). Whereas the self-identified Hispanic population in the U.S. comprises approximately 16% of the total U.S. population, Hispanics are disproportionately uninsured compared to other U.S. racial or ethnic groups. This lack of health insurance is a function of both lower proportional employment rates and a higher proportional rate of employment in sectors in which medical insurance is not offered. As example, data from 2010 have indicated that approximately 30% of Hispanic adults work for

employers who do not provide insurance for their employees, as compared with approximately 13% of Caucasian employees who work under similar circumstances (De Jesus and Xiao, 2012).

Regarding explanation for this demographic disparity in health service provision, the lack of health insurance for Hispanic individuals results from multiple factors, the two most significant likely being the high rate of Hispanic representation in agricultural employment (including forestry) and the high rate of migrant/seasonal labor and undocumented laborers within this employment sector. As reported by Arcury and Quandt (2007), ~ 85% of migrant and seasonal farmworkers in the U.S self-identify as Hispanic, with ~75% of this demographic born in Mexico, 23% born in the U.S., and the remaining 3% from Central and South America and the Caribbean. The remaining ~15% of migrant and seasonal farmworkers in the U.S. are principally non-Hispanic individuals from Haiti and elsewhere in the Caribbean, as well as individuals from Mexico and Central America who self-identify as indigenous (and who do not speak Spanish as a primary language). While approximately half of this overall population of migrant and seasonal laborers hold U.S. residency in some form (either citizenship or legal permanent residency), half are undocumented (Arcury and Quandt, 2007). According to the National Center for Farmworker's Health (NCFH)[1] and Hoerster et al. (2011), there are an estimated 3 million migrant and seasonal farmworkers in the U.S. Based on the assumptions presented by Arcury and Quandt (2007) and Hoerster et al. (2011), this overall number suggests an estimated 1.5 million undocumented agricultural workers in this country.

[1] http://www.ncfh.org [Accessed 10/24/20]

Migrant farm laborers or farmworkers are a demographic identified both by their employment in the agricultural sector and a seasonal (or shorter) basis to establishment of temporary homes. Migration between employment opportunities may be regional or national (the 'follow-the-harvest' scenario involving travel between locations that grow different crops) as well as international, with some percentage of farmworkers returning to their home country between harvest seasons. For farmworkers who have participated in census counting, approximately 75% identify as male, with around half of this demographic migrating for work with their families (Arcury and Quandt, 2007).

Regarding the provision of health insurance for this demographic, workers' compensation is the primary insurance in the agricultural sector, and it not a requirement that it be provided for seasonal and migrant farm laborers (Frank et al. 2013). For farm laborers in the southeast, as example, workers' compensation is not required in some states (including Alabama, Arkansas, Georgia, Kentucky, Mississippi, South Carolina, or Tennessee), while in others (Florida, Louisiana, North Carolina, and Virginia), it is provided, but coverage can be limited by numbers of days worked and numbers of employees, factors that are generally outside of the control of individual laborers. Importantly, even when workers' compensation may be available, there are a range of structural deterrents (e.g., fear of being singled out, fear of losing employment, awareness of lack of ability to redress wrongs if fired) to seeking it out, as well as the reality that – unless explicitly educated on what protections exist and how to navigate the system to access these protections – it is likely that many migrant and seasonal farm laborers are unaware that financial protections for work-related (and work-ending) injuries exist for them. Importantly, as

well, is the reality that as a primary means of health insurance coverage, workers' compensation protection (if it does exist for individuals in specific jobs) does not extend to laborers' families.

In terms of injuries, immigrant workers worldwide experience higher rates of occupational exposures and injuries than non-immigrant workers, leading to poorer health outcomes, including higher rates of occupational fatalities (Moyce and Schenker, 2018). Conditions leading to overall poorer working conditions for immigrant workers include lack of union protection; lack of access to safety training; lack of access to more stable and less dangerous work; language barriers; structural power imbalances that limit workers' abilities to advocate for themselves; challenges in physically accessing health services (resulting from long working hours in often rural locations without availability of transportation); discriminations based on gender, race, ethnicity, and social status in home countries (e.g., indigenous versus Hispanic workers) and overt biases about what services migrant laborers actually *need*. Holmes (2007) describes, as example, interactions with a Mexican social worker and a U.S. apple orchard manager in Washington state discussing the different working arrangements for indigenous Mexican Triqui people versus Hispanic Mexicans. In both interactions, the decisions regarding which communities receive the more lucrative agricultural work are framed in terms of what types of work are perceived as more *suitable* for two distinct caste demographics of Mexican migrant laborers. Holmes (2007) documents being told "*Oaxacans [Triqui people] like to work bent over….whereas Mexicans get too many pains if they work in the fields*". Likewise, in discussion of apple picking:

> "The O'xacans are too short to reach the apples, they're too slow. ... Well, they have to use ladders a lot more than some of the other guys. The other guys just use the ladders to pick the very top of the tree, where the O'xacans are having to, you know, halfway. ...

> And, besides, they don't like ladders, anyway. [Triquis] are perfect for picking berries because they're lower to the ground."

Overall, for farmworkers, health service needs result from both lifestyle exposures and occupational exposures and injuries. Lifestyle and occupational exposures include increased risks of skin ailments, including skin cancers, and eye problems including cataracts and redness, itching and blurred vision, all as the result of un- or under-protected outdoor work. Lifestyle exposures also include increased potential exposure to infectious disease. The risk of contracting tuberculosis, as example, has been reported as up to 6× higher for migrant and seasonal farmworkers than for other physical laborers (Arcury and Quandt, 2007), and current risks from SARS-CoV-2/COVID-19 are likewise elevated for this demographic.[2] Increased risks of tuberculosis and SARS-CoV-2, both typically spread person-to-person, result from a combination of overall poorer health within the migrant and seasonal labor community as well as exposures through housing and transportation conditions (e.g., poor ventilation and over-crowding) that facilitate the transmission of respiratory diseases. Although data are limited, rates of sexually transmitted infections, including HIV/AIDs, may also be elevated in this demographic for reasons including lack of education, poverty, isolated living conditions and frequency of interactions with commercial sex workers and/or individuals engaging in transactional sex for money or security (Arcury and Quandt, 2007).

Occupationally, injuries are most commonly the result of repetitive motions (e.g., climbing, bending, picking) or events that result in single-incident injuries (e.g., falls from ladders and injuries resulting from working with farm equipment). While these categories of

[2] http://www.ncfh.org/msaws-and-covid-19.html [Accessed 10/25/20]

injuries are presented separately, they are not unconnected, as stiffness, sprains, dislocations and musculoskeletal disorders resulting from repetitive motions (as well as overwork, exhaustion and prolonged work at very high or very low temperatures) likely result in increased worker susceptibility to more serious accidents. Moreover, as has been documented anecdotally by recently-arrived, undocumented immigrants, the pressure to 'over-perform' at work as a means of demonstrating value as a worker and maintaining employment status results in both fatigue and increased likelihood of injury (Flynn et al., 2015). In physically-demanding and dangerous occupations such as agriculture (including forestry) this tendency to over-perform, including working too quickly and with disregard for ergonomics and safe maneuvering in the vicinity of mechanized equipment, increases occupational risks significantly.

Occupational chemical exposures are also a significant concern for migrant agricultural laborers and include herbicides and pesticides (at either/both acute and sub-acute levels of toxicity), as well as direct exposures to plants and other infectious agents that can cause rashes or other skin conditions. Arcury and Quandt (2007) summarize research suggesting that approximately half (46%) of farmworkers surveyed report rashes as the result of either seasonal temperature factors or the harvesting of specific crops. Moyce and Schenker (2018) report that among the 2+ million agricultural workers in the U.S., there are between 10,000 – 20,000 pesticide exposure-related injuries treated annually. It is unknown what fraction of the overall likely chemical exposures this range of treatment cases represents. While personal protective equipment (PPE) may be made available by the employer to limit chemical exposures, reported limitations on the use of PPE by migrant farmworkers include requirements to purchase the equipment from employers and limited availability of safety training information for those who

would benefit from use of PPE (reported in Moyce and Schenker, 2018). Reported scenarios in which safety training information, including proper use of PPE, has not be made readily available to farmworkers include: as the result of scheduling constraints posed by the seasonal mobility of the migrant labor workforce; training information not being translated into workers' native languages; and training information being presented in ways that presume literacy (Hege et al., 2015). Concerns regarding availability of PPE and proper training in its use are particularly acute in 2020 with respect to COVID-19 because of the disproportionate impact of the SARS-CoV-2 virus on racial and ethnic minority communities[3], as well as the role these communities play in creating and maintaining the U.S. agricultural and service sector economies. NCFH reports, as example, that widespread shutdowns in meat packing and food processing, as well as widespread layoffs in the agricultural production sector, are resulting from SARS-CoV-2, either as the result of positive COVID-19 cases or following mandates to enforce social distancing for limiting viral spread.[4] These shutdowns/layoffs disproportionately impact the migrant labor workface because of their over-representation in these industries.

As an additional category of health concerns within this demographic are both mental health challenges and chronic physical illnesses. Arcury and Quandt (2007), in evaluating research assessing mental health status for migrant laborers, conclude that greater than 30% of the individuals evaluated reached medical criteria for diagnosis of depression and anxiety. Reasons for acute mental health concerns within the undocumented migrant population are obvious and include isolation, fear of deportation, physically and mentally abusive and intimidating working environments, lack of social supports, illiteracy, the inability to navigate

[3] https://covidtracking.com/race [Accessed 10/23/20]
[4] http://www.ncfh.org/msaws-and-covid-19.html [Accessed 10/25/20]

linguistic and cultural challenges, the physical difficulty and financial instability of farm work, challenges in finding and maintaining stable housing for oneself and one's family, overall employment insecurity and substance ab/use as a coping strategy to alleviate these stressors (Flynn et al., 2015; Hege et al., 2015). Regarding chronic physical illnesses, research suggests that farmworkers are at elevated risk for diabetes and heart disease (Villarejo, 2003; Frank et al. 2013), both conditions often going un- or under-treated. Factors contributing to chronic illnesses are also obvious and include limited income, limited ability to maintain consistent medical contact, poor food quality, food instability and hunger, and the resultant stresses associated with being unable to manage health choices for oneself and/or one's family.

In terms of individual insurance coverage, Frank et al. (2013) estimate that only 10% of migrant and /or seasonal laborers have any form of private medical coverage, and public benefits such as Medicaid, Medicare and State Children's Health Insurance Program (SCHIP) are not available to migrant and/or seasonal laborers without legal documentation. While the U.S.-born children of farmworkers are eligible for Medicaid, and can qualify for nutritional benefits through the Women, Infants and Children (WIC) program[5], these services are not widely available to non-U.S. born siblings, a situation that creates obvious challenges within migrant labor families. Although undocumented immigrants can access Emergency Medical Assistance (EMA) for emergencies requiring hospitalization, EMA does not include provision for follow-up care. The lack of integrated follow-up care under EMA highlights a further challenge for migrant workers in that in the absence of EMA or readily available access to Community and Migrant Health Center (C/MHC) care, the act of seeking medical, dental or mental health support outside

[5] https://www.fns.usda.gov/wic/frequently-asked-questions [Accessed 10/25/20]

of a direct emergency context carries with it a range of risks. Risks include the potential for identification and deportation as well as discomforts/shaming (either accidentally or on purpose) from U.S. health care providers. In this context, health care providers may not have familiarity with the migrant labor community and their health concerns, or may not have comfort or competency with the laborers' native languages (including not just Spanish, but Haitian Kreyol and indigenous languages, e.g., Mixteco, Triqui, Tarasco and Quiché) or understanding of alternative culturally-based frameworks for conceptualizing 'illness', how it occurs and/or how to improve health.

In the U.S., what health services are available for migrant laborers are provided principally through a network of Community and Migrant Health Centers (C/MHCs). These Centers, also known as Federally Qualified Health Centers (FQHCs), are community-based, federally-funded and non-profit, and serve clients including those without insurance, the homeless, and migrant agricultural workers, forestry workers and fishermen, as well as their families (Frank et al. 2013). Importantly, C/MHCs are permitted by law to offer access and treatment services without requiring confirmation of immigration status. While insufficiently distributed to meet rural agricultural workers' needs, C/MHCs are located in every state, and through a network of approximately 1,200 service centers[6], deliver care to over 20 million people (Frank et al. 2013).

C/MHCs provide transportation, interpretation, case management, health outreach and basic health services including medical, dental, and mental health, as well as referrals for treatment of substance use disorders (Frank et al., 2013). These services are provided either

[6] http://www.ncfh.org/migrant-health-centers.html [Accessed 10/24/20]

directly or via mobile units, tele-health technologies and/or trained community outreach workers (e.g., *promotores de salud*) or community health workers (CHWs). Community outreach/health workers commonly function as a bridge between patients and medical staffing because of their specific familiarity with the language, culture and customs of the community within which they work. Along with outreach workers, staffing at C/MHCs typically includes primary care physicians, nurse practitioners, nurse midwives and physician assistants. Basic medical health services provided under the C/MHC mandate include primary care, laboratory diagnostics, immunizations, child health services and health screenings for some cancers, lead exposure, cholesterol and communicable diseases, and pre- and peri-natal care (Frank et al., 2013).

While C/MHCs exist on paper – and, where possible, in reality - as a network of service provision centers for uninsured patients, challenges with transportation, available Center hours, consistent Center staffing and cultural and linguistic constraints on easy access to services often limit their utility for undocumented migrant labor communities. It is worth noting here that although the Center or Clinic model in which patients come to the medical staff to receive care is the model that many would consider the most 'efficient' for provision of medical services, efficiency is ultimately a less relevant metric for successful utilization of medical services than 'access.' This statement is particularly true for a client base (i.e., undocumented and/or uninsured migrant labor communities) who, themselves, have been structurally impeded from prioritizing 'efficiency' in any significant decision-making for healthcare or otherwise.

Recognizing these limitations of the C/MHC model, the U.S. Federal Health Resources and Service Administration (HRSA) Bureau of Primary Care (BCP)[7] also works to administer innovative programs, including the provision of vouchers to allow farmworkers access to care at community clinics, as well as funding to non-profit organizations addressing the structural impediments to health care access for this demographic. Non-profits supported by the BCP have included social justice organizations such as Farmworkers Justice Inc.[8] that focus on litigation support for occupational chemical exposures, advocacy surrounding housing reform, and HIV/AIDs outreach, education, and access to treatment; and the NCFH (discussed earlier) which provides technical training, health outreach information and data on the demographics and needs of the U.S. migrant and seasonal farmworker population. As presented by NCFH, as example, based on a summary of patient visits from 174 Migrant Health Centers, there were approximately 1,000,000 agricultural worker patient visits in 2018.[9] Of these approximately one million patient visits, 96% of the patients self-identified as having income below 200% of the Federal poverty level (i.e., income within a factor of 2 of the Federal poverty line). Of significance for access to services for these individuals, 65% did not speak English well enough for English to be a suitable language for provision of health information or treatment directives.

As noted previously, the C/MHC model relies significantly on community outreach workers, mobile clinics and lay health advisors to bring services to communities in need. In the context of undocumented migrant farmworkers, this outreach-based, community-centered approach to providing care has significant potential for improving worker access to basic

[7] http://bphc.hrsa.gov/ [Accessed 10/25/20]
[8] https://www.farmworkerjustice.org [Accessed 10/25/20]
[9] http://www.ncfh.org/fact-sheets--research.html [Accessed 10/24/20]

services. The challenge remains however, in maintaining a frequency and consistency of contact with a migrant or seasonal population to assist in providing support for conditions that go beyond the need for only acute medical interventions. This challenge is likely particularly relevant for chronic conditions such as diabetes and hypertension for which sustained, regular access to medication is a necessity of treatment success; for behavioral and educational interventions such as providing culturally-inclusive and medically accurate information or access to condoms to limit exposure to sexually transmitted infections; and in situations in which lay health advisors may be working to promote safe working conditions in locations in which their efforts may be viewed by owners/management as interventionist.

Due to legal, linguistic and cultural barriers such as these described, as well as practical limitations including lack of consistent transportation, migrant and seasonal farmworkers utilize health care services significantly less often than other populations at a similar income level. A 2005 study examining frequency of health care use by migrant farmworkers and their families, suggested that only approximately 20% of migrant and seasonal laborers reported accessing any health support services in the 2 years prior to the survey (as reported in Frank et al. 2013). Challenges with accessing health support services have been framed in recent years in terms of the 3C Model (e.g., Brandenberger et al. 2019). In the 3C Model, challenges to accessing quality and consistent medical support are a function of (1) communication; (2) continuity of care; and (3) confidence in the U.S. medical system (Brandenberger et al, 2019). In the context of this Model, communication refers to the ability of medical staff to both present and understand information exchanged with a patient regarding symptoms, treatment options, potential treatment side-effects and treatment prognoses. Communication in this framework is therefore a two-way

exchange that can easily suffer through linguistic limitations as well as cultural biases in all aspects of doctor-patient (including patients' families) interactions. Included in this category of communication bias is also the role that professional versus personal (i.e., known to the patient) interpreters play in facilitating communication, and recognition that the preferences of doctors for trained interpreters often run counter to the preferences of family members for a non-technically trained, but trusted, family member to serve in this role (Brandenberger et al., 2019).

Regarding continuity of care, Brandenberger et al. (2019) summarize four aspects of facilitating medical access that are important for supporting the concept of continuity: (1) provision of information to migrant and undocumented communities regarding what medical supports are available; (2) support for these communities in understanding the extent to which supports that are available are easily accessible (e.g., in terms of clinic hours, availability of transportation etc.); (3) the ability to flexibly mesh (if possible) medical appointments/scheduling with migrant labor work requirements; and (4) demonstration that clinics – fixed or mobile – are competent in maintaining medical records (to the extent that the patient provides records and wants them maintained) so that subsequent care visits build on the outcomes of previous visits. As a significant challenge to the development and maintenance of continuity of care, Brandenberger et al. (2019) note, as well, that the concept of medical screenings (such as for high blood pressure, skin cancers or lesions, and pre-diabetes) and preventive medical visits often exist outside of the cultural framework of many individuals, not just migrant laborers. That is, if it is not in your personal experience or cultural background to assign value to visiting a doctor while nothing is apparently wrong, then there is nothing in the medical framework of screenings and preventative check-ups that is intuitive for a potential patient. As the third

element of the 3C Model, integration of both communication and continuity of care results in confidence. In the context of the Model discussed here, confidence is the belief that medical service professionals will provide useful, appropriate recommendations and treatment with a demonstration of respect and care for the patient and their families (Brandenberger, 2019). These recommendations and treatments should be offered in an environment that is supportive without stigmatization regarding income or education level, lack of legal documentation or assumptions regarding cultural, social, sexual and/or gender-based or gender-constrained behaviors.

In addition to these challenges and questions of how best to provide care to migrant (and often undocumented) farmworkers, are the larger sociological questions of how this population is seen (or not) within the broader U.S. population. Specifically, to what extent are undocumented laborers seen as morally or ethically 'deserving' of any standard of care in the U.S. This concept of '*health deservingness*' has been assessed across the wider U.S. population, with research over the past decades focusing on the impacts of both the 1996 Personal Responsibility Work Opportunity Reconciliation Act (PRWORA) that defined citizenship as a necessary pre-condition for health service entitlements and the more recent 2010 Affordable Care Act (ACA) that specifically excludes undocumented adult immigrants from federally-subsidized state health exchanges and the Medicaid expansion (Quesada et al., 2011; Viladrich, 2012; Marrow and Joseph, 2015). Following the passage of PRWORA, which has been described as purposefully aimed at discouraging immigration by eliminating the 'draw' of the U.S. 'welfare magnet', undocumented immigrants were specifically framed as lawbreakers. This framing was based on assumptions of likely counterfeiting of U.S. documentation (e.g., social security cards), working without paying taxes, and taking advantage of government-funded services and programs

(Viladrich, 2012). The result of this framing was the conceptual overlapping of 'undocumented' with 'illegal', a framing that both for the public at large and for the undocumented individual – who although they may be performing a vital role in maintaining U.S. industries such as agriculture – created the potential for externalizing (for the public) and internalizing (for the undocumented individual) a sense of individual and cultural '*undeservingness*' and associated stigma about their status in the U.S. (Quesada et al. 2011).

More recently under ACA, as described by Marrow and Joseph (2015), although funding for FQHCs has been increased with a resultant expansion in the geographic scope of health centers that serve uninsured clients, the homeless, and migrant laborers (including agricultural workers, forestry workers and fishermen) as well as their families, the social boundaries that surround the 'undocumented' have been highlighted even more clearly by the explicitness of their exclusions under this Act. This explicit exclusion further increases the public visibility of the apparent 'unworthiness' of undocumented migrant laborers for health services provision and protection in the U.S. (Marrow and Joseph, 2015). As noted by Quesada et al. (2011), the 'unworthiness' ascribed to undocumented immigrants, often in willful ignorance of the work they do in the U.S. and the reality of socio-economic and security concerns in immigrants' home countries, is culturally reframed in terms of concerns for border security, fear of disease transmissions, financial concerns regarding inappropriate use of an already frayed social safety net, moral failings (i.e., a misguided belief that if someone is willing to enter a country 'illegally', they likely have a higher propensity for other criminal activities) and abstract concerns (also in willful ignorance of the immigration history of this country) regarding the impact of undocumented Latinx workers on 'cultural cohesion' in the U.S. What is lost or

purposefully ignored in this discourse, is, of course, the reality that the economic vacuum, social instability and violence that many immigrants seek to avoid through entering the U.S. is the direct result of historical (and contemporary) U.S. policies and practices 'South of the Border'. In this context, it bears mentioning that nobody actively 'chooses' to become an undocumented migrant farmworker. For more than a million individuals in the U.S. this reality is the direct result of larger socio-economic and geopolitical destabilizations within which individuals are simply seeking employment to support themselves and their families.

This sociological conflict surrounding who is 'deserving' of health care is also played out for undocumented immigrants within their interactions with the medical field itself. In a study of the attitudes of medical support personnel in a community health clinic in Alabama, Bianchi et al. (2019) document that while clinic employees generally agreed that care *should* be provided to all (i.e., 'deservingness' in terms of medical humanitarianism, human equality, and health as a basic human right), many employees interviewed also held personal views around undocumented immigrant status that conflicted with their professional sense of ethics. Personal views related to Bianchi et al. (2019) included belief that undocumented immigrants were taking goods and services that would then not be available for U.S. citizens, as well as a wrestling with the apparent paradox that while one has to be healthy to contribute to society (as 'good' workers are attempting to do by seeking medical support), the act of seeking medical support while undocumented and with at least the perception that one is not paying equivalently for services, increases costs for those who pay taxes (thus, undocumented immigrants as 'bad' free-riders on the U.S. medical system) (e.g., Quesada et al. 2011).

As Bianchi et al. (2019) observe, the act of attempting to navigate the medical system – from seeking clinic information to scheduling appointments to having one's symptoms heard without bias to receiving a diagnosis and arranging a schedule for follow-up care (if needed) – all takes place within a sociological space in which how medical professionals *should* behave overlaps with how these professionals as individuals *do* behave. As such, the biases and beliefs that even professionally trained individuals carry have implications for enhancing or restricting any individual patients' sense of willingness to engage with the medical community. This statement is, of course, not only true for undocumented immigrants, as it impacts access to health care for anybody who does not fit the archetype of the 'model' patient.

In a sociological sense, what is occurring when personal biases or stereotypes 'break through' in the medical context is that medical providers are not seeing the structural vulnerabilities of communities for whom the U.S. medical system – as it is currently constructed – has not been built to support. Holmes (2012), in an anthropological study of the interactions between health clinic providers and migrant laborers in the Pacific Northwest, provides multiple examples of medical provider beliefs and statements that suggest, on some level, a belief that the illnesses and injuries experienced by migrant laborers are the result of individual choice and action or an infantilizing of adult responses based on provider *perceptions* of a patient's behavior. Medical provider statements such as *"[migrant patients]…don't really take care of themselves*" or that workers' compensation claims filed by migrant laborers are the result of laborers "*just trying to work the system*" or that repetitive motion injuries are the 'fault' of the worker performing the activity incorrectly or the following observations of a sympathetic and observant clinic doctor:

> "[w]hen migrant patients pull away during certain aspects of worker's compensation tests, it is interpreted as faking pain, while in reality, it is fear of pain. So, I will go through the same exam and get completely different results. But the suspicions of malingering have already been raised."

all highlight the reality that the perception of medical '*undeservingness*' for the undocumented migrant labor community permeates even the structure of medical clinics with a mandate to treat the un- or under-insured, homeless and indigent. In reality, as long as the U.S. creates and maintains a legal framework that permits the undervaluing of the work, safety, health and lives of undocumented migrant workers (in agriculture or otherwise), broad social changes in how the 'deservingness' of this demographic is perceived will not easily advance. The problems in this case are structural, and to the extent that Federal policies and regulations continue to both actively penalize and passively limit protections for undocumented farmworkers, workplace safety, with all that that should entail, is an unfortunately distant goal for migrant and seasonal agricultural laborers and their families.

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