"Mexican Migration and Healthcare: Transnational Perspectives from Puebla & the New York State Capital Region"

REPORT on Grant #FNN01Y entitled "Mexican Migrant Health Needs in Upstate New York: A Survey and Intervention"

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The bi-national report connects through ethnographic research two particular places by examining how migrants and programs are defined relative to the realm of healthcare, and the role that the categorizations and classifications that emerge from this process play in healthcare access and funding in both Mexico and New York.

Ideological differences toward health and healthcare access necessarily serve as a starting point for this project as these disparate viewpoints are inserting migrants into two radically different scenarios where they have to cope and develop strategies in order to satisfy their healthcare needs. Mexican official discourse and national philosophy posit healthcare as a constitutional right. In the United States, healthcare is characterized as an individual achievement, and by complexity and inequality.

In exploring the space of healthcare as right and healthcare as achievement for Mexican migrants and their families, we've constructed a framework that allows us to compare, contrast and clarify the different kinds of institutional cultures and health experiences in relation to what it means to be a migrant or a migrant's family on both sides of the border. In doing so, and through ethnographic methodology, we arrive at a series of recommendations to be considered in both Mexico and the United States.

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INTRODUCTION

The bi-national report connects two particular places by examining how migrants and programs are defined relative to the realm of healthcare, and the role that the categorizations and classifications that emerge from this process play in healthcare access and funding in both Mexico and New York. We draw on almost two years of ethnographic research in the central Mexican state of Puebla and in three employment sectors–agriculture, service and the Saratoga track – in the New York State Capital Region, where Mexican migration is relatively new and has grown substantially in the past decade.

Ideological differences toward health and healthcare access necessarily serve as a starting point for this project as these disparate viewpoints are inserting migrants into two radically different scenarios where they have to cope and develop strategies in order to satisfy their healthcare needs. Mexican official discourse and national philosophy posit healthcare as a constitutional right. Although, as our fieldwork in Puebla indicates, actual resources may be thin on the ground, vastly unequal and embedded into sets of individual and local concerns and politics, there is general belief that everyone should have subsidized healthcare access. (*cf.* Castaneda & Zavella 2005[2]) In the United States, healthcare is characterized by complexity and inequality. This is due in large measure to the dominance of private sector interests, the history of governmental accommodation, and the scale and elasticity of need (Krugman 2005[3], Castaneda y Zavella 2005.) Special circumstances (for example, gender, age or disability) occasionally indicate state intervention (Castaneda y Zavella 2005.) For many, the often seemingly *ad hoc* nature of healthcare available to migrants and sometimes, the cost involved, make the ability to negotiate this realm in the United States a potential access point to citizenship, both in terms of implicit senses of belonging against a backdrop of undocumentedness, and as part of a dossier of ongoing responsible practice that proves ones eligibility for legal membership. This conclusion is supported through interviews with migrants, particularly those in the service sector; we have conducted in the NYS Capital Region: healthcare, its negotiation and the ability to pay for it are ultimately seen as an achievement.

In exploring the space of healthcare as right and healthcare as achievement for Mexican migrants and their families, we've constructed a framework that allows us to

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[2] Castaneda and P. Zavella, 2005. *Theorizing Cross Border Interventions: The California-Mexico Health Initiative.* Paper presented at the panel, "Political Ecology of Borders," Meetings of the Society for Applied Anthropology, Santa Fe, April 9, 2005.

[3] Krugman, Paul. 2005. *One Nation Uninsured.* New York Times, June 13, 2005.

compare, contrast and clarify the different kinds of institutional cultures and health experiences in relation to what it means to be a migrant or a migrant's family on both sides of the border. In doing so, and through ethnographic methodology, we arrive at a series of recommendations to be considered in both Mexico and the United States.

Our framework includes the following, discussed in further detail and with ethnographic examples and details from Puebla and New York State Capital Region in the body of the report:

1. **Institutional Mapping:** who are the federal, state, regional and municipal players in the field of migrant health care and what, if any, articulations do they have with each other? How their funding is attached to particular modes of eligibility or specific categories of migrants? In Mexico, research was conducted on the program "Vete Sano, Regresa Sano" (VSRS) as it exists within the framework, hierarchy and bureaucracy of the Secretaría de Salud and how it functions in the state of Puebla. In New York, we met with and interviewed providers and advocates at Migrant Farm worker Clinics, Latino Advocacy Programs, local Economic Opportunity Commissions, and met with private practitioners and Department of Health officials from the Migrant and Seasonal Farm worker Health Program, and the Migrant and Seasonal Farmworker Vaccination Program. These many programs compose what we refer to as an *ad hoc* terrain of healthcare, one that is both vulnerable and subject to frequent shifts, providing further barriers to migrants.
2. **National ideological/philosophical approaches** to healthcare and healthcare systems and the differences that these produce in migrant's abilities to access healthcare on both sides of the border. This section has a number of parts that explore in more depth the difference that the two ideological positions outlined above, healthcare as a right vs. healthcare as an achievement, make in migrant healthcare access. This includes the sometimes privileged place of the Mexican migrant in Mexico versus the exclusionary ways in which migrants (with or without documents) are treated in the US. What kinds of barriers to healthcare or confusions about healthcare access do these shifting positions create? In this section, we also ask how different political cultures in the US and Mexico support the ongoing visions and practices of healthcare as a right vs. healthcare as an achievement.
3. **Complexity and Gaps** in the gathering of statistical information. In this section, we explore the problem of unrealistic/improper counting, linkages to funding streams, and the issue of narrowly defined eligibility for healthcare in New York and Puebla, exploring what the consequences of these are for migrants, their families and those who advocate for and provide services for them.

Through a complex institutional mapping, we are concerned with four central themes:

1. How are people categorized/classified as potential recipients of healthcare?
2. How these categorizations affect funding for healthcare provisions and therefore potentially limit migrant access?

3. How knowledge and/or social networks influences migrant access to healthcare in both countries?
4. How migrants, their families and health service providers cope with the gap between official policies and on-the-ground realities?

Among our central research findings are that (1) there are a welter of terms and procedures for how migrant individuals and groups are named and subsequently, categorized; that (2) this represents a process of situated classification, strongly influencing whether (in the US) or how (in Mexico) or how long (in both places) individuals or groups receive health services; and further (3) that this situated classification entangles governmental regulatory practices and bureaucratic hierarchies, funding streams, migrant and migrant family survival strategies, and 'best-faith' health care provision. Our fieldwork indicates that at present, in both Mexico and the New York State Capital Region, migrant and migrant family healthcare is very often accomplished through the *ad hoc* rearrangement of the same resources to reflect new conditions. These resources are meant to serve increasingly larger populations, and indeed, early indicators point to the fact that these programs and funding streams are extremely vulnerable to budget cuts in times of economic crisis. Policy makers concerned with migrant health care must remain vigilant to keep funding sources for these services alive, and to recognize the crucial work of migrant advocates and community-based organizations in meeting migrant health needs.

In July 2006, we submitted a proposal entitled "Mexican Migrant Health Needs in Upstate New York: A Survey and Intervention." In it, we proposed to trace health needs and practices among migrants in the aforementioned employment sectors in the NY State Capital Region to the migrant's home communities, exploring how work practices, household economics and language obstacles influenced access to healthcare. Much has changed in the US and in Mexico since we wrote the original proposal and these changes are reflected in our research shift. In the US, the migrant labor demonstrations of May 1, 2006, debates in the US Congress regarding migration and the construction of a wall as a part of new security measures along the border, and increased public attention to migrants, much of it negative (ie: the maelstrom over making drivers licenses available to all migrants, regardless of legal status in New York and a spate of deportations in the capital region) made the idea of being able to talk to people openly and frankly – a hallmark of the ethnographic study that we proposed – impossible. Although we knew of a large community of Triquis living in Albany for close to twenty years, the political situation in Oaxaca closed the door to tracing that particular sending community. Likewise, in Mexico we found that families and friends of migrants were afraid to speak out in this new environment and to share details about their family members in the United States. We raise this in the first part of our final report because it represents an ongoing and central obstacle to research in migration, one that we continue to hear from new researchers involved in PIMSA projects and elsewhere. Establishing trusted networks through which to interview migrants, their advocates and health providers became a methodological problem that required substantial time to negotiate. As a result, we recommend that PIMSA remain active in cultivating an up-to-date network for migration and health researchers who can provide advice and active assistance to new researchers in this field. We also recommend that researchers maintain and share contacts with

community based organizations and advocates through which much of the everyday world of migrant healthcare access is negotiated.

Our fieldwork has raised as many questions as we have been able to answer. These questions have generated a research proposal submitted by Bilbao for further research on indigenous Chiapanecos' migration to the Riviera Maya and the US. Bilbao and Burrell plan future work on migration of Maya Indians (from Chiapas, México and Guatemala) to the United States. Burrell & Collins plan ongoing research, perhaps under the umbrella of an NIH Export Center grant held by the Center for the Elimination of Minority Health Disparities at U Albany. They are continuing their involvement with networks built during research in order to keep raising the issue of Mexican migrant healthcare access in an area where this population is newly emerging. (See Executive Summary of project results at the end of this report.)

1. INSTITUTIONAL MAPPING. THE MEXICO'S AND THE UNITED STATES HEALTHCARE SYSTEMS

What are the intentions of health care policy in the USA and Mexico versus the everyday reality experienced by migrants? In this section, we elaborate institutional histories and the production of particular kinds of health care terrains that migrants and their families now access or attempt to access in Mexico and New York.

The idea of migrant health needs and access to healthcare systems began to gain new political significance in 1996, when the United States and Mexico integrated these matters into discussions of the Bi-national Commission (formed in 1981) and to sum up efforts made by the Department of Health and Human Services of the USA and the Mexican Department of Health (Secretaría de Salud.) In 1999, both countries signed a border health collaborative bilateral agreement; by 2000, a joint declaration on migrant health was in place, and in 2001 a high level group for migration issues was created.[4] Following these protocols, migrant health as well as border security became a bi-national affair.

México's governmental actions.

The Mexican government's 2001-6 National Development Plan established as one of its objectives the defense of Mexican citizens living abroad. This defense implied the development of programs that viewed migration as a shared responsibility between Mexico and the countries of destination. One of the mandates of these programs is Mexican migrant health relative to the constitutional right to health that all Mexicans have as citizens. This is why, under the National Healthcare Program 2001-6, the Mexican government established a program for migrant health call "*Vete Sano Regresa Sano*" (VSRS) (go and return in good health.) This program will be in place until at least 2012.

The movement of VSRS within the Secretaría de Salud demonstrates the increased political capital that migrants and migration have gained in Mexico. As the chart in

[4] The main objectives of this group are: a) to increase the number of labor visas for Mexico; b) the legalization of Mexicans living in the US; c) to establish a program of temporary workers; and, d) the reinforcement of border security.

appendix 1 indicates, the program was initially located within the Centro Nacional para la Salud de la Infancia y la Adolescencia (CENSIA)[5] and now is under Dirección General de Promoción de la Salud. This change indicates a shift in status under the structural bureaucracy of the federal government. The shift also included a broadening of program objectives to include granting access to healthcare to migrants and their families in the US as well as Mexico.[6]

The main objective of VSRS is to preserve health in the localities that send Mexican migrants, in the country as a whole, and in the country of destination, that is to say in the United States. In other words, VSRS seeks to insure migrant health through health sector actions and the best practices and experiences of private and public health institutions.

It is important to mention that the articulation between VSRS and other federal programs, like "Oportunidades" and state and local governments is uneven. This is the case because not all states or localities have the same level of marginalization[7] or the same margin of migration. In addition, programs like "Oportunidades" are not intended for all needy citizens. "Oportunidades" is a federal Program that seeks to promote the good health of Mexicans through preventive medicine and information campaigns for family planning, diet, sexual education, and family hygiene, and to improve human capital in three fields: education, nutrition and health. Only eighteen states are part of the program and that 53% of the budget is concentrated in five states: Chiapas, Oaxaca, Veracruz, Puebla and Michoacán.

In relation to health, "Oportunidades" seeks to promote self-care and prevention by periodic orientations, educating children –who have scholarships to attend school[8]– and their families in health practices, nutrition and hygiene, and through access to a basic health services package for all the members of a grant holder's household. "Oportunidades", also provides a stipend to children less than five years to prevent undernourishment.[9] The program obligates family members to periodically receive checkups in their local community health centers.[10] "Oportunidades" then, seeks to create a health care culture, previously absent in Mexico that rewards prevention. Despite the best intentions of both "Oportunidades" and VSRS, they both have very broad mandates that are challenged by lack of resources and monitoring.

The articulation between the federal program VSRS and state governments is well illustrated in Puebla. The migration process of poblanos began with the "Bracero Program" and increased dramatically during the seventies with the migration of

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[5] The main functions of CENSIA, a decentralized administrative organ with operative, technical and administrative autonomy, are to establish, promote and evaluate national policies, strategies, guidelines and procedures for the attention of this population health.

[6] VSRS strategy is to work on the inter-institutional coordination under a model call Modelo de Atención Integrada a la Salud del Migrante (MAIS) MAIS is divided in three substantive actions and two strategies. Actions are: information, prevention, and health services. Strategies are: epidemiological vigilance and evaluation.

[7] The marginalization index takes into account information related to access to education, some specific housing characteristics, income and distribution of population.

[8] Scholarships are given for elementary to junior high studies.

[9] "Oportunidades" has been judged so successful in Mexico that New York City has a pilot program "Opportunities New York City" that resembles "Oportunidades" philosophy. (Rosenberg, Tina "A payoff out of poverty?" New York Times Magazine, December 21, 2008)

[10] Missing three appointments rends them ineligible for further continuation in the program.

undocumented Mixteco Indians. Even so, it wasn't until 1990 that the migration issue acquired political significance. Migration was a topic in political campaigns and later, the state government created the Coordinación de Comunidades Poblanas en el Extranjero (CCPE.) In fact CCPE was created as a political response to the federal Secretaría de Relaciones Exteriores initiative that granted state governments a larger role in solving problems related to migration. CCPE was more a program than an administrative structure under Puebla's Secretaría de Economic.

In the 1999-2005 State of Puebla Development Plan, the migration issue had a bigger presence. The plan establishes as one of the main strategies the reinforcement of networks with poblanos who live abroad, establishing "Casa Puebla" in New York City and later on in Houston, Chicago, New Jersey and Los Angeles, California. With "Casa Puebla" the government seeks to increase institutional support and contributions of migrants in the promotion of economic development in home communities in order to reduce migration. The population born in Puebla and now resident in the US has more than doubled from1990 to 2003.

Table 1 Republic of México and Puebla's Population

Entidad	Población 1990	%	Población 2000	%	Población 2003	%
Nacional	5 413 082	100	8 780 482	100	9 866 755	100
Puebla	85 369	1.6	246 361	2.8	305 442	3.1

From 1991 to 2003 remittances increased by more than 100%. In Puebla, remittances have quadrupled in these years.

Table 2 Republic of Mexico and Puebla's Remittances, 1995 and 2003

Entity	1995		2003	
	Amount in million dollars	Percentage	Amount in million dollars	Percentage
National	3673	100.0	13 397	100.0
Puebla	178	4.8	792	5.9

In 2000, Puebla's government created the Coordinación Nacional de Oficinas Estatales de Atención al Migrante (CONOFAM) in which twenty-four state governments participates with the intention to promote integral solutions to migratory problems

emerging in Mexico and the US. With these and other political decisions the government of Puebla has openly recognized the economic and political importance that migration has in the state.

All these political decisions, programs and/or (bi) national agreements resonate differently at the local level. It is at the level of communities where we have ethnographically explored modes of implementation and the differences between what is intended by public policies related to migration and health as opposed to the everyday realities.

Migrant Healthcare on the Ground in the New York State Capital Region

New York State has a long history of migration to agricultural areas, particularly the Finger Lakes District and in the west and to the Hudson River Valley and surrounding areas. The stream of Mexican migrants to the Capital Region is fairly new, growing quickly in the past ten years, reflecting a larger national phenomenon of migrants to smaller cities and new regions in the US.

Maps 1 & 2 (see appendix 2) show some of the terrain of migrant health care provision in New York State at the county and non-county levels. These reflect the state history of migration and also show a notable gap in services in the capital region. As a result, migrants in this area often have a more difficult time finding out about and accessing healthcare because (a) some of the resources are new or changing to reflect a growing population, and (b) people frequently find themselves in very rural areas without information about what is available or the means to access it (transportation, time off from work, etc.) and furthermore, (c) some services are provided according to occupation (i.e.: farm workers, but not diary workers, track workers but not other Mexicans living just outside the track), according to legal status (i.e. those holding H2-A visas or green cards), and region (those living in or employed in one county but not another.) These factors, and the key significance of language barriers, together contribute to a bewildering array of factors for Mexican migrants to consider, particularly when they have come from a healthcare system that, while lacking in resources, is widely available wherever people happen to be in Mexico.

This terrain provides barriers to access for all migrants, regardless of status, occupation, national origin and geographic location. For example the New York State Department of Health (NYDOH) reports that only about two-thirds of the 24,000 migrant or seasonal farm workers (MSFW's) in New York receive healthcare, although it is available. (Carter 2007) Gender, age and length of time in the US across the occupational sectors of agriculture, the track and the service sector add additional complexity to the ways in which this terrain includes or excludes particular migrants. Track workers are the most diverse, coming from the largest number of Latin American countries. Conversely, farm workers tend to be the most uniform, coming from specific states in Mexico, including Puebla, Michoacán and Oaxaca, and from Guatemala. This has implications for their healthcare and willingness to seek access. It also influences the health care programs and organizations available to them. For example, track workers have the best 'on-site' programs; farmworkers have the widest range of government programs available; food service workers, being more urban, are more likely to know about and have access to a variety of doctors, clinics and hospitals.

How you (don't) count

There is wide diversity of Mexican migrants in the capital region in terms of sectors of work, years of residence in the area, their 'status' or authorization for residency and work, their family and household situations. This, in turn, has implications for whether they are counted, that is, whether they are recognized or categorized and registered by various state agencies, NGOs/Nonprofits, or other organizations comprising the 'health sector.' One indicator of this 'counting problem' is the widely divergent estimates of the numbers of workers in given occupational groups, counties or regions (when available); another (as detailed in Section 3) is the uncertainty and protectiveness about statistical information shown by organizations at various levels: local, county, and state; These vary from non-response, to caution about willingness to share, to DOH comments about how 'We'd like that information too', said of clinic utilization figures that a county official describes as 'always being collected'.

Let us give a few examples of the complexities:

- The majority of farmworkers lack the documents, green cards or H2-A visa, authorizing them to work in the US. Therefore, they have to use various strategies to 'not attract attention', to live and work, but remain invisible to the general public and to all official bodies and organizations. The farmers who employ them often will not know about available resources, and they may fear, with some justification, that taking workers to clinics may result in their being identified and deported.
- There are special health programs for migrant farmworkers; those migrants who have moved out of the farm sector but remained in the area, working in, say, domestic cleaning, landscaping, or food service, are not eligible for these programs. These job-changers are quite often the very people who have settled in for the longer term, established or re-united families, and thus have dependents as well as themselves in the local area.
- Food service work, like the emblematic 'restaurant work', is a sector that often operates 'under the table.' Health care insurance is not common, and where it occurs, as is the case for those in Albany working in established diners or for fast food chains, it will cover the individual workers but not their families.
- In different ways, states like New York provide certain absolute guarantees to health care. Pregnant women and people with life-threatening conditions have such peremptory 'no questions asked' status, but they are quite likely not to know these rights. Again, status and fear of deportation affect peoples' knowledge of resources and rights and their likelihood or ability to act or that knowledge.
- Sometimes the pace or timing of work in a given occupational sectors hinders recognition and access to health care. For example, track workers come from many places and if they are assigned to particular horses, will come and go quickly, in a matter of days, before and after given races. As is frequently reported in the literature, the fact that migrant farmworkers move 'with the groups', from place to place and state to state makes it hard to them to get

registered for programs or insurance and to maintain such registration or eligibility as they cross state lines.

In brief, many if not the majority of Mexican and other Latino migrants into this region lack documents or other 'authorization' to reside and work in the US. That means that they live in fear of deportation, and therefore that they practice – and are encouraged to practice – strategic invisibility. This has implications for whether they are registered and recognized in the health and social welfare system; it thus has implications for the allocation of resources into the health and welfare system; it has implications for their knowledge of and access to that system and for their tendency to rely on the 'informal health care' system-of-practices. But the question of recognition, that is, of classification or categorization and subsequent official tabulation, cannot be divorced from the nature of different work sectors and from the larger 'political climate' influencing how migrant workers are seen and treated by the 'host' society.

2. NATIONAL IDEOLOGICAL/PHILOSOPHICAL APPROCHES. HEALTH CARE AS A RIGHT VERSUS AS AN ACHIEVEMENT.

In Mexico, access to health services is a constitutional right, while in the United States, it is an achievement that citizens may acquire; it is an individual matter, that is to say a successful individual gains access to well being. In this sense, Mexican migrants move between these two contrasting scenarios and develop different ways to negotiate health services, and to deal with structural impediments, that is to say, barriers that prevent or limit access to health services.

Health as a constitutional right is a historical product. With the Spanish conquest many new illness appeared in the Mexican territory. A high number of Mexicans died and traditional medicine lost its luster but did not disappear. Later on, during the colonial period, access to resources, among them health services, was a matter of power and available only to economic elites. Meanwhile, the vast majority of the population was limited to traditional medicine, "curanderos" or medical herbs known through oral tradition. The revolution brought with it social liberalism and the concept of social justice and equal rights to all citizens. Health then became a right and a way to give expression to equality. With the institutionalized bureaucracy of the Partido Revolucionario Institucional (PRI) over the course of more than sixty years, followed by the current Democratic regime, access to health services became a way of gaining political clients, recognition and legitimacy. The Welfare State, after all, is meant to meet the needs of its citizens.

There are two main institutions that provide health services to Mexicans. The "Instituto Mexicano del Seguro Social, (IMSS)" was created for the provision of health care services to all private sector employees. Companies or firms have the obligation (until recently) to register all workers under the IMSS and pay a contribution.[11] The "Instituto de Seguridad Social para los Trabajadores al Servicio del Estado, (ISSTSE)" was created to provide health care services to the government bureaucracy. Together, they two entities are intended to meet the needs of the formal sector.

[11] Through different mechanisms like hiring people monthly, some companies evade this obligation.

But in a nation such as Mexico, the informal sector of the economy is a strong one, and sometimes supplies even more jobs than the formal sector. All these workers together with those who live in rural areas and from subsistence agriculture do not fall under the mandate of IMSS or ISSTSE. For this reason, the Mexican government supports a system of rural health clinics (Clínicas de Salud) administered and operated by the Secretaría de Salud, federal programs like "Progresa," "Oportunidades," "Seguro Popular" and "VSRS", and state and local government programs, or private "Consultorios Médicos" and/or hospitals. Within this scenario a vast majority of Mexicans expect health care services.

Achieving Healthcare in Three Employment Sectors in the New York State Capital Region

In the following section, we provide more detailed information for the access of healthcare in the employment sectors in which we explored healthcare options and questions of access and interviewed workers.

Farm workers

The two classifications/categorizations that seem to enjoy the most access to health care in New York State are migrant farmworkers, pregnant women and children. Migrant farm worker health care is well-established in New York State, stemming from the state's historic economic reliance on seasonal agricultural labor. A series of clinics has been functioning state-wide for decades and various methods are in place and develop in relation to serving new populations. At the frontline of this network are clinic visits. Healthcare at this level acknowledges the reality of migrant's lives and provides transportation, healthcare advocates and interpreters to facilitate clinic visits. If no nearby clinic is available to meet the healthcare needs of migrants, a well-known, trusted and circulating 800 number staffed by a migrant farm worker clinic in the Finger Lakes region may be accessed in order to negotiate visits to local providers that are then covered by a voucher system. Finally, hospital negotiating teams can be made available for migrant workers who find themselves in emergency situations.

Depending on the clinic, and the flexibility of clinic employees, advocates and outreach providers, the availability of these services are made in relationship to employment status (with or without visa.) However, this can be flexibly understood; something that we frequently hear about is the strategies of providers to meet contradictory missions and serve the widest possible population. For example, since the employment hierarchy or trajectory in the region often means moving up from agricultural work to the service industry, some healthcare providers will still attempt to provide for those who have been employed on farms in the past years, especially when they have an ongoing relationship with the clinic. Similarly, State DOH offices often recognize the limitations of their mandates viz-a-viz selective use of classification (i.e. migrant workers as those holding H-2A visas.) Some have more flexibility, especially if they follow public health mandates. Nevertheless, the major concern for even the most empathetic providers has to do with the gaps between funding streams that keep their operations running and the classifications associated with them.

It is this nexus of gaps and inconsistencies that we refer to as "situated": context here is negotiated on a case-by-case basis.

Track Workers

The Saratoga track – an important regional employment sector for a couple of intensive months –now has a largely Latino workforce on the backstretch (the non-public part of the track), including Mexicans and Central Americans, but also many South Americans. Healthcare on the backstretch used to mean getting the vet to reset a bone and, if you were lucky, provide some painkillers. (This is in keeping with the 'rugged' imagery associated with those who work with horses.) In the past five years, however, healthcare for backstretch workers and their families has become a philanthropic *cause celebre* among the many of the wealthy patrons, trainers and horse owners, and is also a lightening point for outreach among existing health service providers in the Saratoga area. The Saratoga Planned Parenthood, for example, has a section on their website discussing healthcare offered to this population, even mentioning that some track workers now wait to have annual check-ups with them. Throughout the track season, which runs for the month of August (although migrant workers may be present from April – November), various fundraisers are held to benefit backstretch healthcare providers and other agencies that specifically target migrant workers. By accessing state and federal funding available for migrant workers and by further linking this to private-sector philanthropic fundraising in order to fill in gaps and/or widen healthcare access, Saratoga County has been successful at targeting a much wider and quickly growing population.

Methodologically, however, this sector proved to be among the most difficult to gain access to workers. Partially, this is due to the short season and the long and grueling work days of backstretch workers, and the ways in which their lives of circumscribed by the rhythms of thoroughbred races and the variety of jobs that come with it – hotwalking, stall cleaning, etc. At another level, the politics of the track and the various sectors that provision workers required extensive work to understand and negotiate.

Service Workers & Fiscal Citizenship: Healthcare as Achievement

Among Mexican and Central American migrants to the New York State Capital region, the service sector often represents a significant opportunity to earn more take-home pay in less rural places and to interact in increasingly public settings that showcase language and other skills acquired after significant time spent in the US. However, this is, we find, the sector for which targeted healthcare provision ultimately falls through the cracks. In other words, selective targeting of health care provision and the informal network of advocates and providers is, as of yet, emerging (with, again, the important exception of prenatal care and care for children.) Despite this, our ethnographic data indicates that this is also the sector of recent migrants with the most fully articulated long-range plans to obtain the full privileges of US citizenship. For them, healthcare and their ability to access it and to pay often astronomical medical bills are central to the multiple strategies they employ to meet this goal. Other strategies include applying for and maintaining (when possible) drivers licenses, obtaining Social Security numbers and paying taxes even when wages are not primarily earned in one's own name, and assiduously remaining reachable by U.S. postal services so that documentation and bills arrive. At least

partially, the logic behind this is one of readiness: when possibilities arise for applying for US citizenship or a green card, once can prove consistent residency as well s fiscally responsible residency. If part of living in the U.S. for many people is figuring out strategies for addressing healthcare in the absence of state-sponsored safety net, then these migrants can prove that they have successfully negotiated this aspect of contemporary US life.

The financial stakes to this strategy, however, are often inconceivable. In 2007, one of our Mexican research assistants conducted a number of interviews about health care access and US health care experiences with service sector employees in and around the city of Albany. After two interviews with migrants who'd had extensive experience with the US healthcare system, including costly operations we received the following message from him:

> ... I am surprised about the amount of money that they told me that they have spent in health care. The first one told me around 9 thousand and today the guy told me that he had to pay around 20 thousand, because he was in the hospital almost a month. Is that possible???

(Indeed, and importantly in thinking about the strategy of legibility, documentation and 'proof' of eligibility outside of more formalized mechanisms for gaining citizenship, the same message also asked for information requested by one of his informants on how he could go about paying his taxes.) This attitude is echoed in testimonies of poblanos, who are well aware of what healthcare costs in the United States. Their testimony speaks to their knowledge that a visit to a doctor and the cost of medicine may range from 50 to 500 dollars. A surgery can go as high as 15,000 in the US.

This philosophy of healthcare as achievement, while most frequently appearing among migrants in the service sector in the capital region, is demonstrated differently across the employment sectors (do-it-yourself informality, the accessing of transnational networks for advice and/or prescription drugs, the selective and flexible use of existing services in upstate New York) as another challenge for gaining access to the privileges of US citizenship – a demonstration of ingenuity, creativity, and even moral and fiduciary responsibility necessary to survive in a country where adequate and ongoing healthcare is often elusive, especially for those at the margins.

Provider Flexibility and Ad Hoc Healthcare Provision: New Problems, More People, the Same Resources

In both New York and Mexico, we have encountered numerous examples of the way healthcare providers creatively address new migrant problems, cope with increasing numbers and provide 'good faith' healthcare to migrants. Reports of migrant health access throughout the US and Mexico suggest that these kinds of strategies are frequently part of standard operating procedures. However, streamlining access for migrants' means continuing to note these as exceptions; when these strategies become the rule rather than the exception, policy change is indicated to incorporate them instead of leaving providers and migrants vulnerable to potential ineligibility to serve or be served, or to lose already sorely stretched funding.

Examples of the ways in which providers and migrants seek to inhabit the space between policy and on-the-ground reality include the following:

1. Columbia DOH Outpatient Services Mobile Services negotiates eligibility at their farmworker clinic by widening the time frame during which migrants have worked on a farm. In order to receive services at a NYS DOH MSFW clinic, migrants must have met MSFW eligibility (the establishment of temporary residency) in the last twenty-four months.
2. Hudson River Community Clinics has made an effort to change definitions for eligibility in such programs as Medicare, so that services provided by the migrant farm worker clinics can also be funded by Medicare monies
3. Centro Civico Amsterdam, a Latino community-based organization, counts on individual migrant advocates who connect people who are frequently in very rural locations and speak no English to healthcare and other services. We have found this to be the case in many locations and for many organizations. However, since these advocates are a crucial link for many migrants, we are concerned at the precariousness of their connections (i.e. linkages to one person, or to one cell phone number) and the vulnerability this produces for them. These advocates often work with few resources, and these resources are subject to reduction in times of economic crisis.
4. Saratoga County Economic Opportunity Council employs varied strategies to meet migrant healthcare and other needs. These include extensive fundraising and education (ESL classes for migrants and their families that take into account work schedules and family needs.)
5. Migrants rely on their own networks and knowledge for traditional remedies, medical advice (often from doctors who work in their communities in Mexico) and the delivery of medications from Mexico or Central America. In Puebla, relatives send medicine to migrants using "coyotes" known by the community.[12] Poblanos report that it is extremely rare for migrants to return to Mexico for emergency healthcare.

All of these strategies represent coping mechanisms used by migrants and providers.

In Mexico, migrant health care access has been grafted on to an existing healthcare bureaucracy as migration gains new political currency. This fit is sometimes an uneasy one, as noted in Section 3 of this report. Centros de Salud now become transnational sites where migrants call for medical advice, arrange for appointments and immunizations during trips to their home communities and receive prescriptions which are filled by family members and sent through newly emerging entrepreneurs who have added health to already existing transnational endeavors, or who have developed health as a specialty. "Oportunidades" is another example of how migration is newly situated within previously existing programs, as it targets, through education, a population of young people who envision migration in their futures.

Despite the intentions of VSRS to institutionalize migrant clinic visits before and during journeys to the US, the doctor serving in Malacatepec and Zacatepec indicated that none of the migrants go to visit them before the start the migratory process. In

[12] People have reported to us, in Mexico and the US, that therethey are different kinds of "coyotes." Those ones who are specialized in transporting people, those who to carry medicines and other consumers goods like food from Puebla to New York, and those who transport both people and goods.

addition, the doctor commented on the general good health of the people from this area of Puebla.[13]

Participatory observation and interviews allow us track the uneven nature of health care access in the state of Puebla. In the three communities where we conducted fieldwork, there was widespread acknowledgement that severe structural impediments exist inside the Mexican healthcare system. These demonstrate the existence of a gap between the intentions of a national healthcare policy and what exists on the ground in everyday life. For example, not all communities that send migrants have a Centro de Salud. Where these centers do exist, they are staffed by a doctor, a nurse and an undergraduate student of medicine who is doing his or her Servicio Social.[14] The Centro de Salud infrastructure consists of two or three rooms where the doctor provides the consultation and/or examines pregnant women. The rooms are not equipped for surgery or ambulatory surgery. The Centro de Salud, then, is only meant for consultancy, vaccines and preventive illness. The doctor working in the Malacatepec Centro de Salud mentioned that in the case of emergency, the only thing he can do is to transfer the person to the nearest public hospital, even if it is not the best option for that person. When transfer is necessary, it is accomplished by private car, bus, or taxi, at the expense of patients or their families, as the Centro has no access to an ambulance. Due to these structural impediments, the doctor mentioned that he is most likely to recommend a transfer to the hospital when he knows the patient will not resist the idea. This lack of resources places health care practitioners in a difficult place: if the doctor attempts to treat a person who needs advanced medical care and the patient dies at the Centro de Salud, then, the doctor commented, the Centro will suffer from a bad reputation and no one will visit anymore. The only medicines the center has in stock are for regular illnesses, like colds, stomach pain due to parasitosis or congestions, etc. If the Center does have what a patient requires, it is administered for free; if not, the patient will have to buy it at a pharmacy. Ultimately, the main function of the Center is to provide prenatal care and health services to babies, and to the children and families involved in the program "Oportunidades."

Besides this gap, relatives and migrants interviewed in the three communities indicated that they preferred to see private doctors instead of a doctor working in the public sector. The reasons they gave are various. One is that they have to wait for appointments, usually for at least half a day. Another is that there are poorer people in more need who should receive access to limited resources first. The statement that they get better attention in the private sector always accompanies this kind of argument. In this sense, what they are talking about is something they have learned through the migration experience: good medical attention is achieved by a person's efforts and not because they are entitled to it through a constitutional right. These kinds of local level

[13] The main illness suffered by the population are colds in winter time and gastrointestinal illnesses due to the fact that most people keep domestic animals, like chickens, cows and pigs, living close to them. This is one of the things the doctor is trying to change when he gives the monthly talks to "Oportunidades" families and children.

[14] The Servicio Social consists of a period of time where the undergraduate student works, sometimes with a small scholarship, in order to reward the country the investment it has done on his or her education. This Servicio Social applies to all undergraduate students independently if he or she studied in a public or private university. For medical students the Servicio Social implies a year of services to society.

healthcare realities in Mexico demonstrate the gap between a right and the fulfillment of this right.

3. COMPLEXITY AND GAPS IN THE GATHERING OF STATISTICAL INFORMATION

We have found striking similarities in our work in Puebla and in New York around the issue of statistics and counting of migrants and their families and what it means, allows for, produces or blocks in terms of migrant healthcare access. We have devoted a section of our report to this because the issue of counting and the production and sharing of statistics –making these available to the providers and advocates – is a vector of often extreme dissatisfaction that we have consistently heard about on both sides of the border and one we have experienced ourselves.

In Puebla, doctors complain of being embedded in programs like Vete Sano Regresa Sano where they are asked to collect statistics that get aggregated into larger VSRS numbers without providing them with recognition for their work. They comment that this is demoralizing, and devalues their work and their knowledge of migrant communities. VSRS, they observe, continues to look like a success while the real work with migrants is being done by doctors and nurses who are part of the larger health apparatus in Mexico. Because what VSRS does in terms of migrant health gets aggregated with other health offices, it makes it difficult to sort out what's contributed by the program and what's contributed by the health system. There appears to be inconsistency in numbers served from year to year. The problem with this is that VSRS program has not created its own mechanisms for measuring its advances and limitations.

In Mexico, we have had difficulty in accessing VSRS officials in the state of Puebla, even when we have met them at Binational Forums, where we have been invited to contact them. In New York state, our experience has been that state and county agencies, community-based organization, health care providers and migrant advocates have been quite gracious in meeting, talking and sharing their work with us. They have also been crucial in facilitating contacts with migrant workers. Many of them are aware of the burgeoning Mexican migrant population in the capital area and are working to better serve them, but are aware that little data is available on where they are and what their needs are. Our research is of interest to them in better meeting this goal.

However, in both Puebla and New York, we have run into major obstacles, frequently impossible to negotiate, in obtaining data. Migrant statistics, particularly those on healthcare, seem to take on a ghostly life of their own. People are reported to be compiling statistics in various places and they are never available, sometimes even between state offices, state and county offices, etc. As researchers we have often come up against this problem, have made repeated attempts to follow up on current data on migrant health, jumped through a number of hoops to gain access to these and entered into long-term processes to prove ourselves trustworthy, recommended by colleagues and advocates, and embedded in local networks in order to secure access to hard numbers that are supposedly collected and collated in different places. In Puebla, numerous phone calls and requests for information were ignored, despite aforementioned face-to-face. While anecdotal evidence and conversations with other health researchers suggest that the failure to make existing data available may be part of standard operating procedures in

bureaucracies, for vulnerable migrant populations confronted by complex, confusing and fragile networks for the access of healthcare, the lack of resources that this leads to presents yet another multifaceted obstacle and barrier to healthcare.

In New York State, the absence of data is often related to how people are categorized. For example, the NYSDOH reported 24,000 migrant and seasonal farm workers (MSFW) program for the year 2005 (Carter 2007.) The MSFW Immunization program vaccinated just under 3000 in 2005 and approximately 3250 in 2006.[15] In the capital region, the DOH MSFW project coordinators estimated 500-800 MSFW's in the seventeen counties in and around the capital region. These are workers who establish seasonal residence, and are therefore officially counted. However, the Immunization program suggests that these numbers are much higher as their mandate to provide vaccinations is more inclusive. (Meeting, April 6, 2007). There are no official mechanisms for counting the vast number of migrants arriving in the service sector and the Saratoga track. In both New York and Mexico, these kinds of distinctions – who is counted and why, produce notable inconsistencies in the numbers that are available. The disarticulation produced by these discrepancies in numbers, categories, etc, leads to inconsistency in terms of what's being aggregated with what. This, we recognize, means that it's difficult to produce and acquire basic quantitative and demographic data about populations being served. Yet, given this, is even more important to make what data is compiled, available to providers, researchers and advocates.

How people are categorized produce gaps. In New York State, due to the absence of recent qualitative data, the numbers upon which migrant healthcare are base don't reflect contemporary realities of how many people need to be served and the outreach that is necessary to provide them with care. Categorizations are also built into the definitions of programs. If a program only serves farmworkers, for example, and these migrants are moving out of the agricultural sector, providers are forced to look to different funding streams to meet growing needs. Relationships with healthcare providers often established over years are often cut off due to employment changes or movement in and out of eligibility.

In Mexico, where healthcare is, at least in theory, available to everyone, the problem is one of how a migrant or a migrant's family is defined. VSRS doesn't choose who will be served since it is lodged with a larger health infrastructure. The issue here is that it's impossible to tell if the program is reaching those that it seeks to specifically target. While doctors may ask or know if someone is a migrant, there is currently no way to collect that information and make it available.

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[15] These vaccinations were offered through Migrant Community Health Centers, County Health Departments, Hospitals, Diagnostic and Treatment centers and one private physician, throughout the state of New York. Vaccines were supplied at no cost in exchange for promoting/offering the vaccine and submitting monthly reports tracking usage. The vaccines offered included Hep A & B, Flue, Varicella, Pneumo, MMR, Td and Twinrix. (Polletta 2007)

4. EXECUTIVE SUMMARY. ACTIVITIES OF THE PROJECT

JOINT FIELDWORK

April 1- 8, 2007, Albany, NY: Elena Bilbao, Jennifer Burrell, James Collins; graduate assistants Amarylis La Santa & Alanna Murphy Hoffman; undergraduate assistant Sylvie Ginenthal

TEAM MEETINGS

November 15-19, 2006, San Jose, CA: Elena Bilbao, Jennifer Burrell, Casey Walsh, Carmen Bueno; and, Jennifer Burrell, James Collins, Emiko Saldivar.

September 6-9, 2007, Montreal, Canada: Elena Bilbao, Jennifer Burrell, Casey Walsh, Paola Sesia.

October 14-16, 2007, Los Angeles, CA: Elena Bilbao & Jennifer Burrell.

October 9-11, 2008, México, D.F.: Elena Bilbao & Jennifer Burrell.

December 13-17, 2008, Albany NY: Elena Bilbao, Jennifer Burrell, James Collins; graduate assistants Mónica Sánchez González and James Shuford.

January 10-14, Mexico, D.F. Elena Bilbao & Jennifer Burrell; graduate assistant Mónica Sánchez González

EXECUTIVE SUMMARY ON MEXICAN TEAM.

ACTIVITIES OF THE PROJECT

- Phase 1: exploratory research:
Elena Bilbao went to field work at the Capitol District of New York for seven days during April of 2007. The intention was identified where the Mexican migrants came from, or their places of origin. After this, the whole team decided that the Mexican team will do field work at the State of Puebla.

- Phase 2: cabinet research:
Bibliographic compilation on: migration, Mexico-US migration, Puebla-New York migration, migration and health, and the federal government program for health services and attention "Vete Sano Regresa Sano" and the way this program is articulated with state and local governments and health services paying special attention to what happens in the state of Puebla and the communities where we did field work. Also, the research team work in the review of literature about migration theory and specific works on US-Mexican Migration, as well Dra. Elena Bilbao González and Dra. Alejandra Castañeda Gómez del Campo give two seminars on contemporary migration studies to Social Anthropology graduated students.

- Phase 3: Field Work

-One week field work at the Albany region during April 2007.
-60 days field work at three different Puebla's communities
-During 2007 and 2008 sporadic visits to the three communities and Puebla's state capital.
-The main methodology use in field work was participatory observation, structured and semi-structured interviews, life histories, application of questionnaire and a house by house survey at Malacatepec, Puebla.
- Three days of a round table discussion with the members of both teams for presentation of the main results of the field work and research done by each team and figure out the outline of the bi-national team final report

Results Achieved

Aranda B. Rodrigo.

- Servicio Social Report, a requisite for finishing the studies for a BA on Economics.

Bilbao G. Elena P

- Report to PIMSA on the research status of the project "Mexican Migrants needs in Upstate New York. A Survey and intervention." Los Angeles, California October 16, 2007.

- Organization of an International Round Table called "The new agenda on migration studies" celebrated on December 2007 at Universidad Iberoamericana, Ciudad de México.

- Writing and presenting research news summary at the International Round Table called "The new agenda on migration studies." December 2007

- Writing and presenting a conference on school children's and their social imaginary about migration presented at CONAPO conference on migration. September 2008.

- Commentary's at the TV channel 40 program "La otra urna" on the massive return of migrants due to the US economic crisis, November 2008.

- Article in Preparation: *Mexican Migration and Healthcare: Transnational Perspectives* (Burrell, Bilbao, Collins)

Bilbao G. Elena P y Castañeda, Alejandra.

- Mexican team final report, November 2007

Bilbao G. Elena P. y Sánchez, Mónica.

- Bi-national team final report, December 2008 and January 2009

Castaneda, Alejandra.

- Research and writing of a migration biblioghraphy, 2007

Rodríguez R. Daniel.

- Field work report, Summer of 2007 "Santa Martha household's and migration."
- Presentation of thesis research projects for achieving the grade of MA on Social Anthropology, November 2007
- Co-Conference with Dr. Celia Mancillas Bazán: "Transiciones Familiares. El Impacto de la Migración en las Familias Mexicanas," Foro sobre Migraciones Internacionales, Universidad Intercontinental. México, 2007.
- "...Y nos fuimos pal norte; migración internacional, grupo doméstico y remesas colectivas en Santa Martha Hidalgo, una comunidad poblana de origen nahua" MA Thesis December 2008.
- MA lecture, December 2, 2008, Universidad Iberoamericana, Ciudad de México.

Santillanes A. Nadia I

- Field work report, Summer of 2007, "Las políticas públicas orientadas a la atención en la salud de los migrantes. El caso del programa "Vete sano, regresa sano" en Santa María Zacatepec, Puebla."
- MA thesis projects, November 2007 (not approved)
- Research Project proposed to CLACSO's financing -without success: "Estrategias de los inmigrantes ante la exclusión del derecho a la salud en los Estados Unidos: La insuficiencia de una política en salud integral para los migrantes del municipio de Santa María Zacatepec en la ciudad de Nueva York." 2007
- MA thesis project: "Prácticas y estrategias de migrantes indocumentados para acceder a los servicios de salud en la ciudad de Nueva York: el caso de los habitantes de Santa María Zacatepec Puebla en Nueva York." May 2008
- MA thesis forthcoming.

Graduate students supported:

- One posdoctoral researcher: Dra. Alejandra Castañeda Gómez del Campo
- Three graduate students of the MA Graduate Program on Social Anthropology who participated as research assistants. Universidad Iberoamericana, Ciudad de México:
    a) Moctezuma Pérez, Sergio.
    b) Rodríguez Rodríguez, Daniel
    c) Santillanes Allande Nadia Irina
- One graduate student of the PhD Graduate Program on History, who participated as research assistant. Universidad Iberoamericana, Ciudad de México
    a) Sánchez González, Mónica
- Also, the Project give support to one BA on Economics student for the research needed for the approval of his Servicio Social, a needed requirement in Mexico for all BA students.
    a) Aranda Balcazar, Rodrigo

Scholarly Papers in progress:

- Bilbao G. Elena P

  a) Conference to be given at ICAES International conference, Kunming, China

- Santillanes A. Nadia I

  b) MA thesis forthcoming on the practices and strategies of undocumented poblano migrants to access healthcare services in New York City.

EXECUTIVE SUMMARY ON THE NEW YORK TEAM

RESEARCH

Bibliography

January 2007 – December 2008:
Bibliography on migration, theories of migration, migration and health, US migration, US-Mexican migration, reports and data from federal, state and municipal agencies, collection of statistical data for New York State and the Capital Region (where possible.)

Burrell & Collins conducted a regular migration and health work and reading group from February 2007-September 2008 with graduate and undergraduate assistants.

Qualitative/Ethnographic Fieldwork

April 2007-September 2008
Two years of on-the ground fieldwork (highly concentrated during summers 2007 & 2008) with workers in agriculture, service and the Saratoga track, local advocates, state, federal and local officials, and health care providers. A primary way in which we gathered information was by building relations of trust with various actors who provide healthcare or health-related services (including information) and with migrants and people who employ them or provide them with assistance. Having such relations enabled us to attend events where immigrants gather and to talk and learn from such first-hand encounters, where people were willing to tell us about their experiences with work, health concerns and life as a migrant in the New York State capital region.

- Interviews: over forty-five, approximately twenty with workers in the both the agricultural and track sectors[16] and twenty-five with service workers.
- Attendance at events for the local Hispanic community
- Informal conversations

[16] These numbers reflect the difficulty of accessing agricultural and track workers.

Student participation/training:

In Albany, **we supported six graduate assistants**:

1. Alanna Murphy Hoffman (Spring 2007)
2. Amarylis La Santa (Spring & Summer 2007)
3. Fernando del Campo (Summer 2007)
4. Marx Navarro Castillo (Summer 2007)
5. Ilona Flores (Summers 2007 & 2008)
6. James Shuford (Fall 2008)

Two undergraduate students:

1. Sylvie Ginenthal (Spring 2007): bibliographic research & summaries
2. Samantha Grandy (Spring 2008): bibliographic research & summaries

Graduate student papers:

1. Ilona Flores, Migrant Work: A Negotiation of Social Relationships. Paper presented at session on "Narrative, Identity, and History," at the Northeast Anthropological Association Annual Meetings, Amherst, MA. March 9, 2008.
2. James Shuford, "Illegal Aliens" and Legalized Alienation: The Political Ecology of Migrant Farmworker Health
3. James Shuford, "Illegal Aliens" and Legalized Alienation: Effects of Linguistic Categorization of Mexican Migrant and Seasonal Farmworkers in the U.S.
4. James Shuford, "Illegal Aliens" and Legalized Alienation: Representation and Categorization of Mexican Migrant Farmworkers in the United States
5. James Shuford, MA thesis forthcoming

Additional funding:

1. 2007: Center for the Study of Demographic Analysis (CSDA), University at Albany SUNY, Junior Research Award to Burrell ($5,710)
2. 2008: Center for the Elimination of Minority Health Disparities (CEMHD), University at Albany SUNY, Health Disparities Research Development Award to Burrell & Collins, from NIH (NCMHD) #5RDMD001120 ($5,000)

Papers/talks delivered by Jennifer Burrell

1. Report to PIMSA at the Forum on Migration & Health, Health Initiative of the Americas, Los Angeles, CA, "*Mexican and Central American Migration, Health & Work in the New York State Capital Region.*" October 14-16, 2007.
2. Society for Applied Anthropology/Society for Medical Anthropology, Memphis, Tennessee, March 25-29, 2007. *Informalities and Legalities: Exploring Mexican and Central American Migrant Health Care Access in the New York Capital Region*
3. Report to PIMSA at the Forum on Migration and Health, Health Initiative of the Americas, Zacatecas, Mexico, October 5-7, 2008. *Achieving Healthcare:*

Exploring Mexican and Central American Migrant Healthcare Access in Upstate New York.

4. A talk to the Minority Health Task Force, Albany NY (forthcoming, January 2009)

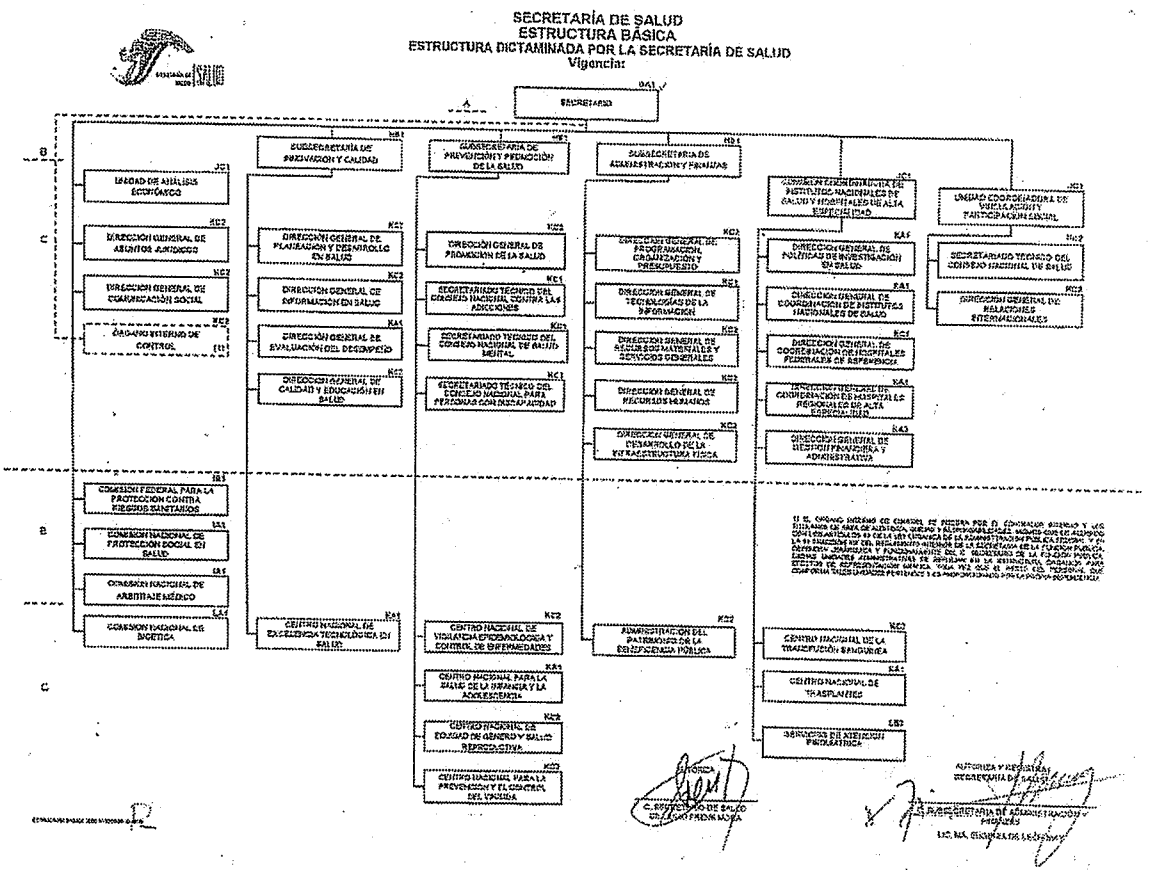
Articles in Preparation:

Achieving Healthcare: Exploring Mexican Migrant Healthcare Access in the New York State Capital Region (Burrell & Collins, manuscript for submission to Social Science & Medicine)

James Collins and Stef Slembrouck, "Classifying Migrants in the Field of Health: Sociolinguistic Scale and the Neoliberal State," In progress (a comparative analyses of U.S. and Belgian data, focusing on issues of language and health access).

Mexican Migration and Healthcare: Transnational Perspectives (Burrell, Bilbao, Collins)

APPENDIX 1

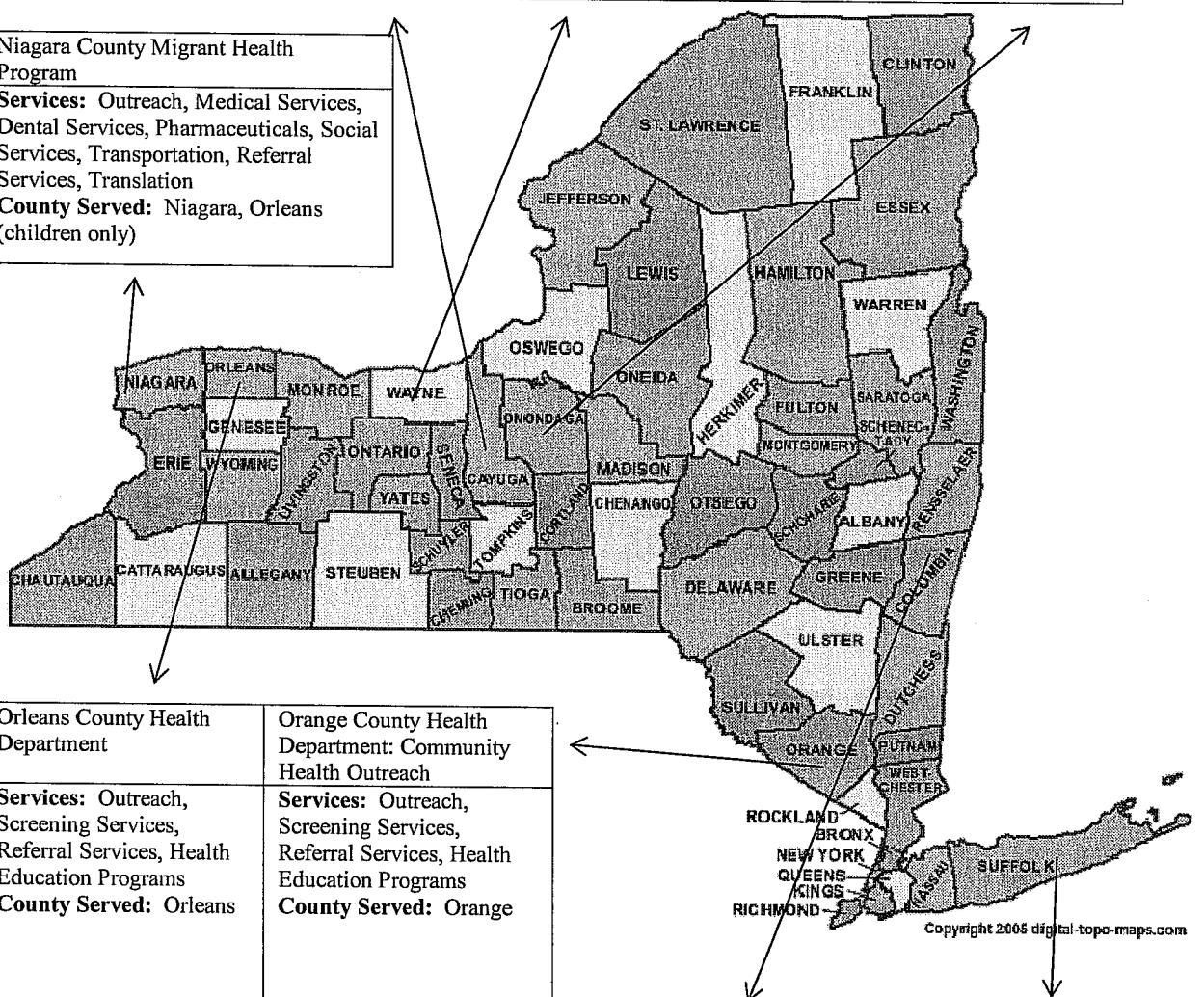

SECRETARÍA DE SALUD
ESTRUCTURA BÁSICA
ESTRUCTURA DICTAMINADA POR LA SECRETARÍA DE SALUD
Vigencia:
SECRETARIO
UNIDAD DE ANÁLISIS ECONÓMICO
DIRECCIÓN GENERAL DE ASUNTOS JURÍDICOS
DIRECCIÓN GENERAL DE COMUNICACIÓN SOCIAL
ÓRGANO INTERNO DE CONTROL
SUBSECRETARÍA DE PREVENCIÓN Y CALIDAD
DIRECCIÓN GENERAL DE PLANEACIÓN Y DESARROLLO EN SALUD
DIRECCIÓN GENERAL DE INFORMACIÓN EN SALUD
DIRECCIÓN GENERAL DE EVALUACIÓN DEL DESEMPEÑO
DIRECCIÓN GENERAL DE CALIDAD Y EDUCACIÓN EN SALUD
CENTRO NACIONAL DE EXCELENCIA TECNOLÓGICA EN SALUD
COMISIÓN FEDERAL PARA LA PROTECCIÓN CONTRA RIESGOS SANITARIOS
COMISIÓN NACIONAL DE PROTECCIÓN SOCIAL EN SALUD
COMISIÓN NACIONAL DE ARBITRAJE MÉDICO
COMISIÓN NACIONAL DE BIOÉTICA
SUBSECRETARÍA DE PREVENCIÓN Y PROMOCIÓN DE LA SALUD
DIRECCIÓN GENERAL DE PROMOCIÓN DE LA SALUD
SECRETARIADO TÉCNICO DEL CONSEJO NACIONAL CONTRA LAS ADICCIONES
SECRETARIADO TÉCNICO DEL CONSEJO NACIONAL DE SALUD MENTAL
SECRETARIADO TÉCNICO DEL CONSEJO NACIONAL PARA PERSONAS CON DISCAPACIDAD
CENTRO NACIONAL DE VIGILANCIA EPIDEMIOLÓGICA Y CONTROL DE ENFERMEDADES
CENTRO NACIONAL PARA LA SALUD DE LA INFANCIA Y LA ADOLESCENCIA
CENTRO NACIONAL DE EQUIDAD DE GÉNERO Y SALUD REPRODUCTIVA
CENTRO NACIONAL PARA LA PREVENCIÓN Y EL CONTROL DEL VIH/SIDA
SUBSECRETARÍA DE ADMINISTRACIÓN Y FINANZAS
DIRECCIÓN GENERAL DE PROGRAMACIÓN, ORGANIZACIÓN Y PRESUPUESTO
DIRECCIÓN GENERAL DE TECNOLOGÍAS DE LA INFORMACIÓN
DIRECCIÓN GENERAL DE RECURSOS MATERIALES Y SERVICIOS GENERALES
DIRECCIÓN GENERAL DE RECURSOS HUMANOS
DIRECCIÓN GENERAL DE DESARROLLO DE LA INFRAESTRUCTURA FÍSICA
ADMINISTRACIÓN DEL PATRIMONIO DE LA BENEFICENCIA PÚBLICA
COMISIÓN COORDINADORA DE INSTITUTOS NACIONALES DE SALUD Y HOSPITALES DE ALTA ESPECIALIDAD
DIRECCIÓN GENERAL DE POLÍTICAS DE INVESTIGACIÓN EN SALUD
DIRECCIÓN GENERAL DE COORDINACIÓN DE INSTITUTOS NACIONALES DE SALUD
DIRECCIÓN GENERAL DE COORDINACIÓN DE HOSPITALES FEDERALES DE REFERENCIA
DIRECCIÓN GENERAL DE COORDINACIÓN DE HOSPITALES REGIONALES DE ALTA ESPECIALIDAD
DIRECCIÓN GENERAL DE GESTIÓN FINANCIERA Y ADMINISTRATIVA
CENTRO NACIONAL DE LA TRANSFUSIÓN SANGUÍNEA
CENTRO NACIONAL DE TRASPLANTES
SERVICIOS DE ATENCIÓN PSIQUIÁTRICA
UNIDAD COORDINADORA DE VINCULACIÓN Y PARTICIPACIÓN SOCIAL
SECRETARIADO TÉCNICO DEL CONSEJO NACIONAL DE SALUD
DIRECCIÓN GENERAL DE RELACIONES INTERNACIONALES

APPENDIX 2

County-Based Migrant Health Services

Cayuga County Health and Human Services Department	Wayne County Public Health Service	Onondaga County Health Department
Services: Outreach, Medical Services, Screening Services, Referral Services, Health Education Programs, Transportation, Translation **County Served:** Cayuga	**Services:** Outreach, Medical Services, Screening Services, Referral Services, Health Education Programs, Translation (written), Interpretation (verbal) **County Served:** Wayne	**Services:** Outreach, Screening, Health Education Programs, Translation, Transportation **County Served:** Onondaga

Niagara County Migrant Health Program
Services: Outreach, Medical Services, Dental Services, Pharmaceuticals, Social Services, Transportation, Referral Services, Translation **County Served:** Niagara, Orleans (children only)



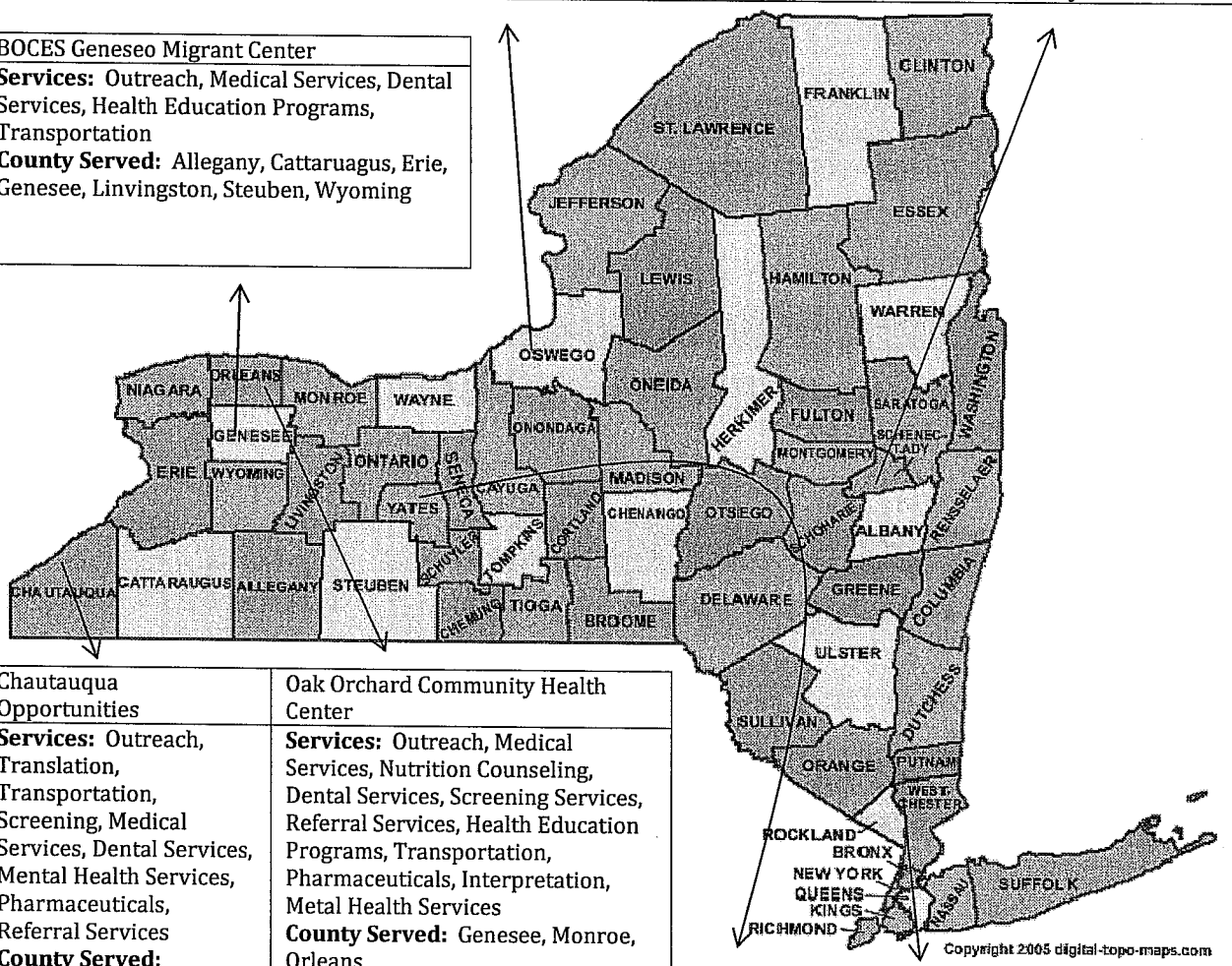
Orleans County Health Department	Orange County Health Department: Community Health Outreach
Services: Outreach, Screening Services, Referral Services, Health Education Programs **County Served:** Orleans	**Services:** Outreach, Screening Services, Referral Services, Health Education Programs **County Served:** Orange

Columbia County Department of Health	Suffolk County Health Department
Services: Outreach, medical Services, Screening Services, Referral Services, Health Education Programs, Translation **Counties Served:** Columbia, Greene, Rensselaer	**Services:** Outreach, Medical Services, Screening Services, Referral Services, Health Education Programs, Transportation **County Served:** Suffolk

Non-County-Based Migrant Health Services

Oswego County Opportunities, Inc.	Agri-Business Child Development Administrative Offices
Services: Outreach, Medical Services, Bilingual Interpretation Services, Screening Services, Referral Services, Health Education Programs, Transportation **County Served:** Oswego (+3 others)	**Services:** Child Development Services, Physical Examination, Screening Services, Referral Services, Health Education **County Served:** Statewide – 13 Child Development/Migrant head Start Centers Statewide Cayuga, Chatautauqua, Dutchess, Erie, Fulton, Genesee, Herkimer, Madison, Monroe, Niagara, Oneida, Ontario, Orange, Orleans, Oswego, Seneca, Steuben, Ulster, Wayne

BOCES Geneseo Migrant Center
Services: Outreach, Medical Services, Dental Services, Health Education Programs, Transportation **County Served:** Allegany, Cattaruagus, Erie, Genesee, Linvingston, Steuben, Wyoming



Chautauqua Opportunities	Oak Orchard Community Health Center
Services: Outreach, Translation, Transportation, Screening, Medical Services, Dental Services, Mental Health Services, Pharmaceuticals, Referral Services **County Served:** Chautauqua	**Services:** Outreach, Medical Services, Nutrition Counseling, Dental Services, Screening Services, Referral Services, Health Education Programs, Transportation, Pharmaceuticals, Interpretation, Metal Health Services **County Served:** Genesee, Monroe, Orleans

Finger Lakes Migrant Health Project	Hudson River Health Care: Hudson River Migrant Health Program
Services: Outreach, Medical Services, Dental Services, Screening Services, Referral Services, Health Education Programs, Transportation, Pharmaceuticals, Interpretation **Counties Served:** Cayuga, Chautauqua, Cortland, Livingston, Onondaga, Ontario, Oswego, Seneca, Steuben, Wayne, Yates	**Services:** Outreach, Medical Services, Dental Services, Screening Services, Referral Network, Health Education Programs, Transportation, Pharmaceuticals, Interpretation, Mental Health Services **County Served:** Columbia, Dutchess, Green, Orange, Putnam, Sullivan (voucher), Suffolk (voucher), Ulster