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Theory Application Paper:
The San Luis Valley and Migrant Health

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Part I

On the day I ate my life changing salad, I was enjoying my day off from the small critical access hospital in Taos where I worked, making a pilgrimage to the nearby San Luis Valley in southern Colorado. I was mesmerized by the dynamic situations of the Great Sand Dunes; the Crestones and Sierra Blanca towered and the vast blue skies above the ancient lake basin gave the illusion of being a bird aloft as I drove the empty scenic routes. A big fan of salads in-season, I am overjoyed when I can find local sources of greens and finding such bounty during my trip was no different. I picked up a piece of lettuce out of my salad, feeling its weight and texture, admiring the emerald green leaf, wondering how many nutrients were still flowing through its veins. I could still see the image in my head of the workers in the field, harvesting this lettuce. *So much in such a little leaf.*

As I drove around the Valley, I noticed the contrast between the nice houses in the east valley and the obvious pockets of poverty in the western, agricultural area. Yet, the folks I had come across, new Hispanic, old Hispanic, white and black were friendly and helpful, no matter their background. Growing up in a mixed ethnicity military family, I never really had roots, never gutturally identified with any group of people or area- until I came to the Taos Plateau/San Luis Valley region. *Home,* I thought bemusedly, *this is what ‘home’ must feel like?* My father, a native New Mexican, had grandparents who were Mexican immigrants and laborers, some of whom settled just north of the San Luis Valley. Again, the image of workers in the fields floated into view.

I was exceedingly curious about the area I was quickly falling in love with. When I returned to my rental, I researched extensively; I pored over everything from a quick “wiki”
history, aerial views on Google Earth, identification of “San Luis Valley Syndrome,” finally resting on the beloved lettuce I had enjoyed. Cesar Chavez should have had a salad named after him; his labor advocacy with migrant workers in the Valley lead to large scale lettuce farm strikes in the 1970s, resulting better wages and living conditions for workers (Garcia, 2017). His focus on nonviolent protests to make the issue heard resonates particularly in current times. Despite this step forward for workers, there remains much work to be done. The San Luis Valley is the most poverty-stricken area in Colorado, having much more in common with neighboring rural New Mexico than the booming Colorado Front Range (Hunger in Colorado’s Historic San Luis Valley Fueled By Geography and Economics, n.d.). Much of farming now focuses on recreational marijuana rather than food production, which also brings into question food insecurity and sustainable agriculture as a mechanism of preventive health. Health care disparities ensue; a landmark longitudinal study in the 1980s focused on diabetes prevalence in the San Luis Valley (Marshall & Hamman, 1993). In the age of ICE and heavy-handed immigration reform and health care reform, many Mexican and Guatemalan immigrants fear making too much of a presence in society- including the health care system- in the event their families are torn apart and they are deported (Tory, 2018). Frequently, children of immigrants must take time away from education to translate for their parents in the event they do seek medical care, or to watch over younger siblings (Honig, 2019). San Luis Valley Health, the predominant health care provider and largest employer in the region, participates in the Colorado Indigent Care Program (CICP), which provides steeply discounted services for Colorado residents who live under the poverty line, are legal immigrants or undocumented migrant workers (Colorado Indigent Care Program / San Luis Valley Health, n.d.). Despite these
resources, the disparities and struggles remain regarding the health and safety of Mexican and Guatemalan immigrants, legal and illegal, in southern Colorado. How can this multi-focal problem be addressed? And how do we begin to conceptualize such a daunting task?

**Part II**

As McEwen & Wills (2019) referenced, ethics and morality are not interchangeable. This is also the argument Willen (2012) makes when discussing how to determine “deservingness” regarding the health care rights of undocumented immigrants in Israel. She presents the viewpoint that health care is a “public good, rather than a commodity” (Willen, 2012). This recalls the philosophical theory of utilitarianism. Utilitarian systems classically seek to make impartial and neutral decisions that promote beneficence for the greatest number of people (McEwen & Wills, 2019; Driver, 2014). While the principles guiding utilitarianism are present throughout history, as a theory and philosophy, it was not explicitly defined until the dawn of Jeremy Bentham and John Stuart Mill during the 1700s and early 1800s. Concerned with social and legal reform, they were eager to see “…useless, corrupt laws and social practices changed (Driver, 2014).” To accomplish this, they formulated a framework with which to judge laws and practices which focused on the principle that the happiness and greater good of all was equal, thus famously, elegantly and succinctly concluding that decisions should benefit the greatest amount of good for the greatest number (Driver, 2014; Mill, 1879). Figure 1 illustrates the principles of utilitarianism.
While it appears that some politicians approach health care as a moral right with punitive measures targeting immigrants, legal and illegal, utilitarianism is an ethical framework closely aligned with the view that health care is a matter of public health, rather than of morality. A review of epidemiological and infectious disease literature robustly supports the health care reform viewpoint that access to care for all people, not just citizens, benefits the greater good (Nandi et al., 2009). In my practice as a nurse in multiple capacities, I have found that an empirically supported utilitarian approach to ethical situations, while imperfect, is most closely aligned with my personal moral compass, decreasing cognitive dissonance in difficult clinical situations. However, a strictly utilitarian approach to these issues is incomplete without context within a grander ecology.

In conjunction with utilitarianism, Promotora de Salud (“promoter of health” in Spanish), an ecological theory, may holistically address the struggles and inequities faced in immigrant communities within the San Luis Valley. Used extensively in Hispanic
migrant/immigrant communities, the utilization of lay community health workers (CHWs), who grew up in the community, has led to better outcomes for poverty-stricken migrant workers employed in the agricultural industry (Balcázar et al., 2012). The origins of the model are unclear, however it is widely accepted that its earliest iterations formed during the Mao Zedong regime in China; “barefoot doctors” were often the only health care practitioners available in remote, rural villages (MHP Salud, n.d.). The model gained traction in Latin America and other Hispanic communities in North America, hence the Spanish language terminology. The role of the *promotora* (female CHW), *promotor* (male CHW), or *promotores* (plural) are detailed in figure 2.
Part III

When approaching the multifocal issues faced by immigrants in the San Luis Valley, we can look to global and local utilitarian and Promotora systems to begin the complex work of problem solving and acting. Canada, one of the nations most similar culturally to the United States, utilizes universal health care coverage. A comparative study examining the role of United States health insurance compared to Canadian universal coverage found that many health disparities faced by immigrants in the U.S. were directly related to a lack of health insurance (Siddiqi et al., 2009). Finland is often the “poster child” for universal health care, including undocumented immigrants; however, despite the country’s “bio-utilitarianism” approach, health disparities still exist between Finnish citizens and immigrants. While free universal cervical cancer screening is widely available, immigrants were significantly less likely to seek screening (Idegen et al., 2018). Another study examined the perceptions of Somali immigrants regarding the maternity health care they received in Finnish hospitals; while the women expressed satisfaction with their care, they also perceived that the health care providers had poor communication and an unfriendly attitude (Degni et al., 2014). This brings not only “bio-utilitarianism” to the table, but “culturo-utilitarianism” as well. Finland is a country known for its introversion and respect for social distancing, even before the time of COVID-19 (D. Lehto, personal communication, June 24, 2020). However, with more gregarious societies, this quietude may be perceived as cold or uncaring. Even in the face of the most inclusive, free health care system, it does not benefit the greater good if it is not utilized by those in society who need it most.
In the case of the Somali immigrants, much of the cultural dissonance could likely have been mitigated using CHWs, who serve a vital role in bridging the disparate worlds of biomedicine and rural marginalized communities. Doctors Without Borders would hardly be able to provide its extensive global reach in poverty-stricken areas without the use of *promotores (Health Promoters | Doctors Without Borders - USA, n.d.).* In fact, an almost entirely *promotora*-based intervention was successful in decreasing the prevalence of diabetes-related complications, a problem of special import in the largely poor, Hispanic populations of the San Luis Valley (Ann Mayes et al., 2010; Marshall & Hamman, 1993). Engaging the community in its health and wellbeing is one of the biggest steps to promoting system sustainability. In a fusion of utilitarian and *Promotora* ideologies, ecological/agricultural and health care sustainability meet and synergize- how do we humanize, refine and ensure that the systems we design can continue to function in a capacity that identifies the uniqueness of the individual/community, while still ensuring the greater good for the global community at large?

Multiple studies examined this intersection of community-based health promotion in the form of community gardens, which not only provide nourishment and exercise for the body, but nourishment for the community as well. Although the landmark San Luis Valley diabetes study brought to light the issue of diabetes and food insecurity within the Hispanic community, it did not examine migrant farmworkers in depth. Quandt et al. (2018) found that migrant farmer families often had trouble travelling to the store and affording nutritious foods, despite working in the very fields that stocked those produce aisles. Another question is whether putting in long days at the fields would sap community members’ energy, precluding planting and maintaining their own community gardens, despite years of farming knowledge? While the
literature is limited, there was a study that precisely examined these issues. Optimistically, the migrant families who elected to participate found that their vegetable intake increased four-fold and they had fewer worries about running out of food between paychecks; the ancillary benefits were of increased mental and physical health related to the act of tending the garden and camaraderie with other families included in the study (Carney et al., 2012).

Despite the myriad benefits, what are the limitations of both the utilitarian and Promotora models? In both cases and in different ways: resources. Returning to the Finnish example of utilitarian health care, although availability of resources may be exceptional, perceived ability to access those resources allows health disparity to remain. In the case of Promotora, Balcazar et al. (2006) explained that their interventions to reduce cardiovascular disease in Hispanic populations were hampered by a lack of sufficient resources and funding to provide organizational support to their CHWs. In terms of data collection, due to cultural reasons and the nature of interactions, it was not always possible to provide accurate, organized and timely data (Balcazar et al., 2006). It is also a potential limitation that members within the community cannot or will not participate in a promotora fashion, leaving a gap in health care delivery.

What is the current state of health care and other resources for immigrants/migrant farm workers in the San Luis Valley? The CICP provides discounted health services to people with low incomes at participating health facilities throughout the state (Colorado Indigent Care Program (CICP), 2014). San Luis Valley Health, the primary health care provider, participates in this program (Colorado Indigent Care Program | San Luis Valley Health, n.d.). Although the state website says that participants must be legal residents to take advantage of this program, San
Luis Valley Health, the primary provider in the valley, additionally stipulates that migrant farm workers are eligible (*Colorado Indigent Care Program | San Luis Valley Health, n.d.*). This is important, as the San Luis Valley Immigrant Resource Center does not provide health care services, only legal services, domestic violence safe houses and counseling (*The San Luis Valley Immigrant Resource Center, n.d.*). While this is better than nothing, data was unavailable regarding the extent to which these resources are either actually available, whether the community knows they exist, or if the resources are being utilized if these conditions are being met. The *Promotora* concepts seen in figure 2. of outreach worker, liaison and health care navigator would be invaluable to assess these questions regarding health disparities as they relate to the community, from within the community. Although this may require more extensive resources, the utilitarian benefits to the entire San Luis Valley community would be palpable. For example, research has shown migrants are at higher risk for mental illness, including schizophrenia, due to multi-focal stress and frequency of PTSD (Abbot, 2016; *The San Luis Valley Immigrant Resource Center, n.d.*). Schizophrenia, while not a cause of violent crime, has been correlated with increased incidence (*Fazel et al., 2009*). With increasingly prohibitive immigration reform under the current United States political regime, immigrants/undocumented migrants fear seeking too many services for fear of deportation (Tory, 2018). Ensuring that health services, including mental health services, are available and accessible will not only benefit individuals, but the safety and happiness of the whole community.

Unfortunately, even the most cost-effective programs require money as well as manpower. Although the hospital receives funding from the state, there appears to be a dearth
of ancillary/satellite services in the rural areas that need them most. A simple review of the Rural Health Information hub reveals a multitude of grants and funds, with some focused specifically on programs for “refugees” and those experiencing food insecurity (Colorado Funding & Opportunities - Rural Health Information Hub, n.d.). With funding, it would be possible to recruit and train promotores, in person or via digital means, to function in their role as patient advocates and health coaches, caring for the community on a day to day basis; building on this, Colorado is an APRN autonomous practice state, permitting APRNs to collaborate with RNs in mobile, primary-care focused unit to take health care to the fields, neighborhoods, churches and schools, utilizing promotores as liaisons, translators and community advocates to bridge the divide with providers (The Mobile Clinic Project at UCLA - UCLA Health Community Engagement - Los Angeles, CA, n.d.). Some of these funds would also be designated specifically for the creation of community gardens and greenhouses, supplying food in some of the more isolated and arid parts of the valley, fostering wellness for a great number of people, contributing to the concepts of food security and sustainable agriculture as a mechanism of health.

**Part IV**

The fusion of these models has great potential to improve the health and wellbeing of immigrant/migrant farm working communities. A utilitarian provision of health care services will benefit the entire community, not just those marginalized populations seeking its services. However universal coverage by itself is not enough; the inclusion of Promotora de Salud, a community health worker-based model, will bridge the cultural divide often seen in utilitarian health care systems, Finland being a prime example. A cost effective and successful model used
by organizations in poverty-stricken areas at the grassroots level, or as widespread and well known as *Doctors Without Borders, Promotora de Salud* adoption has improved patient outcomes globally (Balcázar et al., 2012; Costa et al., 2015). Although there are few statistics regarding utilization of the CICP by immigrants and migrants in the San Luis Valley, a landmark study in the 1980s revealed the problem of diabetes in San Luis Valley residents of Hispanic descent, and more recent articles highlight this region’s issues with food insecurity (*Hunger in Colorado’s Historic San Luis Valley Fueled By Geography and Economics*, n.d.; Marshall & Hamman, 1993). Unique initiatives fusing telemedicine and the *Promotora* model led to better outcomes in Hispanic participants regarding diabetes management, as well educating Mayan migrant farmworkers about occupational safety (Ann Mayes et al., 2010; Spears et al., 2012). Community gardens, a beneficial method of fostering community wellness, both mental and physical, have shown multiple benefits, from fostering community resilience, increased vegetable intake in families and increased happiness for all participants in the United States and Brazil (Carney et al., 2012; Costa et al., 2015). While these models are promising to address the issues of food insecurity, sustainable agriculture as a preventive health mechanism, poverty, diabetes, health care disparities and immigration reform, they are not without limitations. Utilitarian health models in the absence of transcultural literacy allow marginalized populations to remain as such (Idehen et al., 2018). The *Promotora* model, through use of trained community members, overcomes this limitation, however funding still remains a barrier at times, as well as absence of willing community members or health care services (Balcazar et al., 2006). In Colorado, funding opportunities exist to further develop these initiatives, however data is limited regarding the current state of implementation in the San Luis Valley (*Colorado*
Funding & Opportunities - Rural Health Information Hub, n.d.). Future opportunities, particularly data collection regarding feasibility and cost, include fund utilization to outfit a mobile clinic, taking health care to the community and fields (The Mobile Clinic Project at UCLA - UCLA Health Community Engagement - Los Angeles, CA, n.d.). In the age of COVID-19 and ICE, a greater expansion of telehealth is also predicted, with increased utilization of technology and tech-savvy promotores as liaisons, counselors, advocates and translators, allowing the most efficient triage and allocation of limited resources, while still maintaining confidential, culturally sensitive care (MHP Salud, n.d.).
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