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Migrant Health: A Harvest of Poverty

[Article]

Sandhaus, Sonia BSN, RN, C

Sonia Sandhaus is a staff nurse at Moses Taylor Hospital in Scranton, PA, and a graduate student at the University of Scranton in the Family Nurse Practitioner Program. She has visited camps for migrant workers close to Scranton.

Outline

Abstract

Migrant laborers' limited resources and isolation lead to compromised health.

The American agriculture industry relies heavily on the labor of migrant workers. This vast labor force, composed mostly of people of Hispanic, African, and Asian descent, is vital to the economy and contributes to the current wealth of the United States. But these primarily foreign-born laborers are often deprived of basic rights such as safety, sanitation, and decent wages. Moreover, the constant threat of deportation has created a work force living in fear. This fear, coupled with substandard housing and dangerous employment conditions, threatens the health of farmworkers and their families.

According to the National Advisory Council on Migrant Health, nurses and nurse practitioners are the primary health care providers for these workers, and their knowledge of case management and practice is crucial at migrant health care sites. But the Advisory Council also found in its 1993 study that less than 20% of this group makes use of services at these centers. This fact makes it essential that we understand the culture and environment of the migrant worker.

Sojourners in a hazardous environment

The poor health status of the migrant laborer stems from unsafe living and working conditions and health programs that provide fragmented services. Access to health care for this group continues to be limited by language barriers, legal and financial difficulties, as well as a lack of providers.

The average migrant farmworker spends approximately six months per year doing seasonal work (for which he or she earns $5,000, less than half of the U.S. poverty threshold), eight weeks doing nonagricultural work, eight weeks on the road, and is unemployed for ten weeks.

There are five million migrant farmworkers in this country, and agricultural labor-the nation's third most dangerous industry-jeopardizes their well-being. Mobility, long days performing heavy labor, and improper nutrition threaten their health. Laborers also face exposure to pesticides, overexposure to the sun, and lack of proper sanitation and water facilities.

The infant mortality rate among migrating laborers is 25 times higher than the national average. Their life expectancy is 49 years, compared to the national average of 75 years. The rate of parasitic infection is 11 to 59 times higher than that in the general population, and malnutrition is higher than in any other subpopulation in the country. Deaths from influenza, pneumonia, and tuberculosis are 25% higher. The largest outbreak of typhoid in recent history occurred in a Florida migrant laborers' camp and was traced to contaminated water. Research suggests that the high rate of dental disease and chronic illnesses such as hypertension, anemia, and diabetes result from a lack of access to health care.

The workers are unfamiliar with using health systems because health is eclipsed when work is primary. These laborers are unavailable for appointments during the day and lack transportation, funds, and supervised child care. They are therefore likely to seek medical care only when their health becomes seriously compromised.

The culture of migrancy

Living apart from established local communities, this population becomes less visible and more vulnerable to isolation and neglect. Fear of deportation, poverty, and limited education also intensify social isolation.

The typical transient laborer is a young Mexican man whose family members often join him after he has found temporary work. The family may live in close quarters in community housing that barely meets minimum standards. This often cramped and unsanitary housing increases disease transmission, and may also lead to violence and abuse.

Migrant workers have little control over their employment conditions, which may affect their health. Some common stressors include exploitation by crew leaders, unstable incomes, and limited seasonal employment. Also, local communities, when faced with people markedly different from themselves, may become hostile to the newcomers. The farmworkers may be viewed as potential carriers of disease who pose health threats.

The children of these workers suffer homelessness, lack of friends, frequent relocation, poverty, and schooling interruptions, posing psychosocial and developmental risks. Children are essential to the core group's economy and must help in the fields and at home. Unfortunately, this often creates health risks for children; data indicates poor immunization and dental records, stunted growth, and higher rates of accidents and injuries.

It must also be added, however, that migrant workers from cohesive communities based on language, food, music, religion, social interactions, and beneficial folk health practices, promoting family structure. Therefore, it's crucial that their health service providers acknowledge cultural diversity and incorporate appropriate social support networks into their care.

Evaluating health services

No clearly defined leadership to develop policies for migrant workers now exists. Federal appropriations for these workers remain low, and most existing services exclude them because of residency requirements. The government's funding structure provides incentives for agencies that treat a greater number of patients rather than stressing quality, disease prevention, and continuity of care. An effective national tracking system to maximize services is desperately needed.

The National Advisory Council on Migrant Health advocates universal health coverage for laborers and their families with Medicaid coverage transferable from state to state. It recommends that migrant health centers provide culturally sensitive health care-which includes transportation, translation services, and case management-to the diverse and underserved migrant populations.

Currently, most translators employed at health care sites are clerical support staff. Untrained personnel can impede effective health care delivery if they are unable to translate accurately or disregard confidentiality.

Delivering care to a mobile workforce

One successful attempt to address these problems is the North Carolina Maternal and Child Health Migrant Project. This program overcame stringent barriers to health care such as limited transportation, communication difficulties, and lack of child care. Women in the migrant camps were trained to become lay health advisors who now provide health education, prescription instruction, and first aid. Bilingual staff also streamline follow-ups, referrals, and appointments, and act as interpreters. The program uses a bus, as well as volunteer drivers, to transport clients to appointments.

The North Carolina Community Health Center has made similar progress promoting breastfeeding among mothers. Using incentives to attract women to breastfeeding classes, health care workers provided layettes donated by migrant ministries as well as Women, Infants, and Children's Supplemental Food Program (WIC) vouchers on days when classes were held. During routine nutrition education appointments, friends and relatives were encouraged to attend and support women with breastfeeding instruction.

Small classes that stressed individual counseling in the preferred language with language-appropriate teaching materials created a positive climate. The success of this program centered on a support system of other migrant women and on addressing breast-feeding's benefits for these women, such as the ease of traveling with a breast-fed infant as opposed to having to rely on refrigerated formula on long car trips or in migrant camps without electricity. Lower rates of illness among breast-fed babies also meant fewer work days lost.

Another model intervention strategy was instituted by the Camp Health Aide program. Camp health aides were recruited to overcome language restrictions and negative stereotypes that prevent laborers from obtaining proper health care. Camp health aides, themselves workers, helped reinforce positive health values and created a sense of self-esteem and empowerment.

The challenge of providing a uniform strategy of care for a highly mobile population has prompted the development of a compilation of goals for the year 2000 by the National Migrant Resource Program. These goals include better health, fewer risk factors, increased awareness, and improved services. Other objectives are to improve nutrition, immunizations, occupational safety, prenatal care, dental health, preventive services, and medical records; and to reduce drug and alcohol abuse, violent behavior, mental illness, adolescent pregnancy, and HIV transmission. These objectives both complement and enhance the National Objectives for the Year 2000 initiated by the Office of Disease Prevention and Health Promotion of the National Academy of Sciences.

The road ahead

The transient nature of this work force makes it difficult to ascertain its numbers. The lack of data on migrant workers inhibits study, program development, and assessment of conditions. One specific goal for the immediate future is to improve research and data on migrant workers.

Toward this end, NPs working closely with this population can gather information concerning changes in family relationships and acculturation to be used in designing health programs. This would ensure that health services match the needs of specific migrant cultures.

Strategies for interagency collaboration related to NP case management should be identified and implemented. Continued efforts must be made to conduct research assessing risks and hazards, especially pesticide exposure. Many government publications have documented the despair and isolation of migrant workers. Their living and working environments contribute to their diminished health, and must be further studied so that these conditions can improve.

Migrant farmworkers can barely afford the produce that their grueling, underpaid labor provides. Efforts must be made to ensure that they, as representations of a vital component of the American economy, also enjoy this harvest of bounty-along with improved health and living conditions.

For more information, contact:

National Advisory Council on Migrant Health; The Migrant Health Branch; 4350 East-West Hwy., Room 7-4A1; Bethesda, MD 20814; (301) 594-4303

National Center for Farmworker Health; 1515 Capital of Texas Hwy. South, Suite 220; Austin, TX

78746; (512) 328-7682

Migrant Clinicians Network, Inc.; 1001 Land Creek Cove; Austin, TX 78746; (512) 327-2017

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