Resource ID#: 4441

218 MAY-JUNE 1994
JOURNAL OF DENTISTRY FOR CHILDREN

Invisible children: The children of migrant farm workers

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Edward R. Murrow's often rebroadcasted 1960 portrayal of migrant farm workers in the television program *Harvest of Shame* – images of hardworking, exploited and desperately needy people – has become the basis of our stereotyped images of the tragic world of the migrant farm worker. But if this "...documentary were to be replicated now, both the interviewers and the interviewed would most likely be speaking Spanish."[1]

During the first half of this century, there were two distinct groups of migrants engaged in farm work. The first was predominantly non-Hispanic white, U.S. citizens traveling with families to follow crops northward, primarily from homes or locations in the southern and western states. The second major group entered the migrant stream during the 1940s through a series of agreements between the governments of the United States and Mexico. These agreements marked the beginning of Mexico becoming the ongoing source of a majority of migrant farm laborers.[1]

While many thought that mechanization would decrease the need for farm workers, in actuality there was an expansion of the workforce needed to produce fruits and vegetables as fewer workers were needed to produce cotton and sugar beets. The most recent estimates are that fewer than 280,000 of the nation's two million crop-farmers actually follow the crops. But 40 percent of this group bring their families to the worksite. As a result, there are almost six hundred thousand children of migrant workers in the United States at some time during the year. Most travel with their families to do agricultural work, but once here, most do not follow the crops.[1]

Information from the Migrant Clinicians Network Survey indicates that among migrant children, "...otitis media, upper respiratory infections, nutritional diseases, dental diseases, conjunctivitis, parasitic infections, and work-related injuries occur with a frequency much higher than in the U.S. national population.[1]

It is essential in caring for the children of migrant farm workers that health practitioners pay particular attention to the socioeconomic setting within which the youngsters are reared. Yet the reality is that many health providers have limited or virtually no experience (and very probably limited interest?) with the children of migrant laborers.

"...the need will be to transcend the few directions that many dental students learned in dealing with Spanish language patients, *Abre la boca, Cierra la boca, and Escupe.*"[2]

It is in an effort to "introduce" these "invisible" pediatric patients that the following presentation is directed.

SOURCE OF DATA

The National Agricultural Workers Survey (NAWS) includes information on seasonal farmworkers who currently are employed in crop agriculture and who have travelled at least seventy-five miles in search of work.

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The NAWS does not count individuals employed in agriculture associated industries (e.g. processing and packing) and dairy or poultry farming.[3] Although overall national studies of the oral health of migrants and their children have not been carried out, the consistency of the results from the reports on studies of local conditions, as well as the Migrant Clinicians Network Survey, do provide a general picture of the oral health status of the "invisible children" in many of our rural communities.

In addition, since the vast majority of migrant laborers are of Hispanic origin, (particularly from Mexico) (see below) the general findings for Mexican-American children from the only recent national study that collected data on the oral health status of Hispanic children (the Hispanic Health and Nutrition Examination Survey conducted between 1982 and 1984 by the National Center for Health Statistics) will be used for comparative purposes.[4]

AGRICULTURAL MIGRANT WORKER DEMOGRAPHICS AND RELATED DATA

Consider first, the migrant farmworker. Estimates from the National Agriculture Worker Survey (NAWS) indicate that:

- ☐ There are three movements or streams of workers. One stream includes Texas and north to the central plains region. A second consists of California to the Northwest and western states. The third stream includes Florida and north along the east coast.

While there are changes in the patterns, there are general trends in these movements. Families from Puerto Rico frequently travel to the Northeast and mid-Atlantic states. Families from Mexico migrate to California and Texas. Families from Canada migrate to Maine.

- ☐ Forty-two percent of the approximately two million U.S. crop farm workers are migrants. (Note: not all migrants actually follow the crops. Some remain in particular locations for varying periods of time.) Of those, 60 percent are immigrants and 31 percent are parents accompanied by an average of approximately two children (or about 587,000 children) during 1990.
- ☐ Depending on region, between 71 and 82 percent are of Hispanic origin (94 percent of whom were born in Mexico). In the Southeast, Northwest, and Southwest regions of the country, minorities make up 90 percent of the workforce. For example, in 1980, less than 10 percent of the farm workers in North Carolina were from Mexico. Ten years later, the state's peak workforce was mostly Mexican. This "Mexicanization" came in the wake of U.S. citizens finding better nonfarm jobs and the result of farm labor contractors and Mexican workers forming networks to fill these farm jobs.
- ☐ Some states are considered by a large percentage of migrant families to be their "home base" or place from which they start their migration and to which they return after they complete their seasonal work (e.g. California, Texas and Florida). Other states have large numbers of migrant families during the agricultural season (e.g. Minnesota and Wyoming).
- ☐ Sixty-five percent of migrants are less than thirty-five years of age.
- ☐ More than three-quarters are male.
- ☐ Sixty-four percent are married. Seventy percent are married and/or have children. Fifty-seven percent work with their families at the work site.
- ☐ Fifty-one percent have been in the U.S. longer than eight years.
- ☐ One out of five has no work authorization from the Immigration and Naturalization Service.
- ☐ Fifty-three percent have an eighth grade or less education. Most do not read or speak English.
- ☐ Most migrants (83 percent) "shuttle" between home bases abroad (usually Mexico or Central America) and U.S. farm sites. Only 33 percent follow the crops within the U.S.
- ☐ Fewer than half are covered by unemployment insurance.
- ☐ Fewer than a quarter have health insurance.
- ☐ They are paid by the hour with a median income of $4.85 per hour. Fifty percent earn less than $7,500 per year. The median annual income of authorized workers is between $5,000 and $7,500 and between $2,500 and $5,000 for nonauthorized workers. Fifty percent of families are below the poverty line. Eighteen percent received some type of government operated social service program assistance in the past two years (e.g. food stamps [16 percent], and Aid to Families with Dependent Children [3 percent]).[1,2]

CHILDREN OF MIGRANT LABORERS

"...in the fields it is normal for children to be working at a very young age. Most migrant families are large and cannot survive on a single income ... I was 10 years old when I first started working ... With 14 people in

the same house it is very difficult to make ends meet."[1]

Consider next, the children of migrant agricultural workers.

- ☐ Forty-eight percent moved at least once during the past year.
- ☐ Eighty-four to 94 percent qualify for free or reduced cost school lunches.
- ☐ More than one-third are one or more grades behind their age-appropriate grade level.
- ☐ Lack of fluency in English interferes with the classroom work of approximately 40 percent of the students.
- ☐ Over 40 percent are estimated to be achieving below the 35th percentile in reading.
- ☐ Some have little to no exposure to formal education.

In all states, to greater or less degree children of migrants laborers are enrolled, however, in educational programs, ranging from fifty-four in New Hampshire and seventy-one in West Virginia to almost 34 thousand in Florida, more than 60 thousand in Texas, and almost 80 thousand in California.

DENTAL HEALTH AND CARE OF THE CHILDREN OF MIGRANT FARM WORKERS

During the past twenty years a series of studies have documented the oral health of the children of migrant workers in particular communities and sections of states. The reports from these studies (which include references to similar findings from earlier periods) indicate that:

- ☐ "...it is evident that the migrant (black) child was almost completely lacking in dental care except for possible treatment of an emergency nature." (1971)[5]
- ☐ "The unmet dental caries need of (the children of Mexican-American migrant workers) ... remained constant at 75 percent for all age groups (3-13 years)." (1981)[6]
- ☐ "Given the high percentage of decayed teeth, low level of restorative care, and the indications of oral hygiene neglect, it appears that the dental health needs of this highly mobile population are not being met adequately and should receive greater attention." (1984)[7]
- ☐ "...the prevalence of (dental) disease for this population (children of migrant farm workers) continues to exceed the national and regional average." (1987)[8]
- ☐ "The literature documents a significant decline in the prevalence of dental caries among children. Unfortunately, dental decay rates of children of migrant workers remain high." (1990)[9]

The results from the national study of Mexican-American and other Hispanic children are comparable to the findings from local studies of the children of migrant laborers.

"Mexican-American children from families with low annual income have about two times more decayed teeth than children from high-income families ... (the) data also show a high percentage of Mexican American children have mild gingivitis." (1987)[4]

While the DMF rates of Mexican-American and "white" children were comparable, the decay component for Mexican-American children was almost triple the rate for "white" children.[2]

"But limitation in access to health care by Hispanics is not confined to dental services. As with dental services, the ability of Hispanics to obtain general medical care is hampered by relatively low incomes, lack of health insurance coverage and ties to a particular health provider." (1986)[10]

In addition, the particular difficulties in care for the children of migrants (especially those with disabilities) is related to the general perception of the potential action of government agencies. "There is the aspect of fear that government is going to take away the child."[1] Thus many disabled children are not identified.

FROM THE PRACTITIONER'S PERSPECTIVE

"The success of the community (pediatric migrant) projects ... (resulted from) the dedication and enthusiasm of the (dental) students who do not receive credit for their efforts. In the words of one of them, they do it because *it needs to be done*." (emphasis added)[11]

Outsiders who are unable or unwilling to put down roots in our communities, different cultures and languages, and limited finances—do we need any more reasons not to be concerned with these children? Individual practitioners cannot be expected to shoulder the burden of providing dental (and medical) care to scores, hundreds, or more children that pass through their communities. Nevertheless, these are children in need of health services and as long as we continue to employ migrant farm workers, collectively we inherit an obligation to provide the care for their families. This is the message that must be communicated to our legislators as they consider the national programs for health insurance. Surely with the availability of financial sup-

port, "the outsider with no roots in our communities, and with different cultures and languages" would readily be accepted in an individual dental practice.

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PREVENTING TOBACCO USE AMONG YOUNG PEOPLE

This year's surgeon general's report on smoking and health is the first such report to focus on young people. From extensive data that indicate that tobacco use is a pediatric epidemic, the report reached six major conclusions: (1) Nearly all first use of tobacco occurs by age 18. (2) Most adolescent smokers are addicted to nicotine. (3) Tobacco is often the first drug used by young people who subsequently use illegal drugs. (4) There are identified psychosocial risk factors for the onset of tobacco use. (5) Cigarette advertising also appears to increase young people's risk of smoking. (6) Communitywide efforts have successfully reduced adolescent use of tobacco. This commentary restates each of the six conclusions, summarizes the data that support each, and then considers the implications of the conclusions for public health action.

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