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Background

An estimated 1 million men, women and children in the United States depend on migratory farm labor as a chief source of annual income. They are drawn from a population reservoir of 2 to 3 million low-income rural people in the South and Southwest. In these so-called "homebase" areas of migrants, the problems are likely to be most acute, in part because of seasonal unemployment which may last for several months.

Nine hundred of the Nation's 3,100 counties have 100 or more persons from the migrant farmworker population residing within their boundaries annually for varying periods ranging from a few weeks to most of the year. Nearly all States have at least a few coming into local areas to meet peak season labor needs for crop production and harvesting.

Migrants belong chiefly to Spanish-speaking, Negro, Indian and low-income "Anglo" minorities. The majority of migrant adults have not gone beyond the eighthgrade in school. Nearly three-fifths of the household heads and wives who did farm wage-work "on the road" during 1965 had annual family incomes of less than $3,000. The median income of households headed by migratory workers was $2,700. Households average four persons.

Migrants' homes are typically substandard, temporary shelters with meager facilities and equipment for food storage or preparation. Usually the source of water for all family uses is outside the shelter. Sometimes even the source of the supply is unsafe.

Nutritional level

Severe nutritional problems are common among migrants. Evidence of these problems include low hemoglobin levels, poor skin and muscle tone among infants and children, high parasitic infestation, sheer physical apathy attributable in part to lack of adequate food, and a high frequency of tuberculosis.

Systematic evaluation of hemoglobin levels among adult migrants at a California migrant clinic showed an average of 9.6 and 13.0, respectively, for women and men, compared to 12.6 and 14.2 for women and men patients at the Kaiser Hospital in Oakland.

Extracts from the California State report of migrant health services chiefly for families of Spanish-speaking background showed medical visits for the following disorders related directly to nutrition during two recent years:

	Clinic visits (number)	
	1966-67	1967-68

Scurvy	1	-
Rickets	-	1
Other malnutrition	88	92
Obesity	542	474
Iron Deficiency Anemia	208	318
Unspecified anemia	37	-
Cirrhosis of liver	2	-
Total Clinic Visits	34,273	53,697

In addition, during 1967-68, the California project reported 300 visits for parasitic infestations, and 374 visits for diabetes. More than 1,500 visits were for diagnosis and treatment of conditions of the teeth and supporting structures.

For the Nation as a whole, a sampling of medical conditions among migrant patients reported by grant-assisted migrant health projects was compared with a sampling of those seen in private physicians' offices during a comparable period (from the National Disease and Therapeutic Index). Infective and parasitic diseases, and digestive system diseases, were from two to five times as large a proportion of the total conditions seen among migrants as among the general population. Among the infective and parasitic diseases, tuberculosis was seen 17 times and infestations with worms 35 times as often among migrants as among private physicians' patients.

A 1969 study in Palm Beach County, Florida, points to deficiencies in protein and iron intake among migrant adults, chiefly Negroes. Of 118 adults examined, more than one-fourth of the men and two-fifths of the women were obese, defined as 20 percent or more in excess of the desirable weight. However, 40 percent of the men and 56 percent of the women were judged to be anemic on the basis of laboratory tests.

A dietary intake study in Maricopa County, Arizona, during the winter of 1964-65 included 561 persons in 93 families. Sixty of the families were of Spanish-speaking background, 21 were Anglo-American, 9 were Negro and 3 were Indian. Eighty percent of the families had incomes ranging from $1,000 to $3,000 per year. More than half of their yearly earnings were spent on food. Surplus commodities were available to 30 families.

Eighty-two families had stoves with ovens but often the ovens did not work. Nine families had no refrigeration and four had iceboxes but ice was not available.

for citrus fruits, 19 percent consumed none; for green and yellow vegetables, 35 percent consumed none; for other vegetables, 48 percent consumed none; and for meat products, 14 percent consumed none.

Most of the adults were at least 30 to 35 pounds over normal weight, and dental caries prevailed in all age groups.

A dietary intake study among Negro migrant families in south Florida reported on in the early 1960's showed similar deficiencies in the consumption of milk and milk products, vegetables, citrus and other fruits, and animal proteins. Some of the children examined showed evidence of scurvy, rickets, nutritional anemias, and marasmus. There was one case of kwashirkor. The report of this Florida study observed that "the amount of money available for food indicates that very careful planning and budgeting are necessary if migratory families are to have adequate diets." It also observes that although need for education is apparent, such education would have to take into consideration housing, cooking equipment, the hours the mother spends in the fields, and other factors.

A similar food consumption study of Negro migrant farm workers in a New York State labor camp in 1969 also showed deficiencies. The one real meal consumed each day usually consisted of beans and rice, luncheon meat sandwich, potato chips and wine or coffee.

Federal food programs

In a few areas, the various food distribution programs administered by the U.S. Department of Agriculture are reaching migrants. Major problems in their application to migrants are the complete lack of any program for food distribution in some migrant-impact areas, and the lack of any system to gear the program to the migrant situation in most areas where foods are distributed. The relative advantages and disadvantages of each existing distribution method will be discussed, program by program, taking the migrant's point of view.

a. Commodity distribution program

The major advantage of the commodity distribution program is that foods are made available at no cost to the recipient. The disadvantages are many. Usually the single State agency designated to administer the program is the welfare agency. The typical eligibility requirements are applied and migrants must be certified on an individual or family basis. Even if this hurdle can be overcome, and migrants are found eligible on the basis of income, local residence and other requirements, there are still other hurdles. The following are examples:

1. Time-consuming nature of eligibility determination. The migrant may have left for another area before the process is completed, or he may have found

different income, family size, liquid asset and other criteria in each.

2. The commodities are limited and are geared to dispose of farm surpluses rather than to provide a well-balanced family diet.

3. Often the commodities are not part of the customary diet of migrants of various ethnic backgrounds. They may in some cases be completely foreign and the family may have no knowledge of what to do with them.

4. Distribution may be at a point many miles distant from the migrants' temporary living quaters and the cost of transportation is a deterrent to obtaining the food.

5. Distribution may be on a one- time-a-month basis and the packages for a family are of such size that a small truck is required to haul them. Moreover, the family's usual one-room shelter has no storage space for such quantities.

6. If the family's departure date from the local area is within a short time, the commodities are likely to be dumped, since the crowded car, bus or truck used for family transportation does not provide space for transporting large quantities of food, especially food that is not especially palatable to family members.

7. The time of day when foods are distributed may be such that a migrant must lose a day's work to take advantage of the program.

b. Food stamp program

A major advantage of the food stamp program is the ability of the family to purchase what they want, in the quantities they need, when they want it, at the usual retail food outlets. Disadvantages include:

1. Eligibility certification requirements similar to those for commodity distribution.

2. Families typically must pay in advance for stamps. Sometimes they do not have cash in hand at the time that payment is required and they, therefore, must go without stamps until the next day - perhaps a month later - on which payment may be made.

3. Families returning from northern work areas with meager funds to tide them over periods of unemployment at their homebase, may be very reluctant even to make the small outlay for stamps. In some cases they may not fully realize the benefits derived from turning these stamps in for amounts of food considerably in excess of what they could purchase for cash.

the stamps may be worthless to them in the new area.

5. Principles of family budgeting to make scarce income cover more of a family's needs are not well understood by many migrant families. Nor do they understand nutrition principles, and how to make wise selection of food items from both price and nutrition points of view.

c. School lunch

Where school lunches are served, a migrant child has a chance to obtain at least one nutritious meal. However, many rural schools lack school lunch programs. Some lack facilities and equipment to conduct a program. Also in many schools a payment must be made for the school lunch. Even though small, if there are several children in a migrant family, the total payment for all children may be a real tax on meager incomes. Again the value of school lunches in terms of better nutrition may not be fully understood by the children or their families.

d. Emergency food and medical assistance

This program is so limited in its application in migrant-impact counties as to be of little value to migrants. Special effort is being made however, through community action agencies in a few home-base counties, chiefly in Texas and New Mexico.

Migrant Health Program (PHS) in relation to nutrition needs of migrants

The program conducted under the Migrant Health Act of 1962, as amended in 1965 and 1967, enables the Public Health Service to make grants to public or private nonprofit organizations to pay part of the costs of migrant family health services. Grant assistance averaging 60 percent of total cost is provided to 118 single- and multi- county migrant health projects, serving about 300,000 migrants in some 300 counties. The current grant appropriation is $7.2 million, and unless extended the program will terminate June 30, 1970.

Basic health services such as medical, dental, hospital, and nursing care are provided in these projects, coupled with health education and sanitation services.

Part of the health education carried out through projects is concerned with nutrition counselling. Some projects have also been able to help get food distribution programs extended to migrant families.

The following are examples of nutrition services reported by migrant health projects:

1. Collier County, Florida

She also advises on normal nutrition for infants and adults.

2. Maricopa County, Arizona

The nutritionist provides direct service in the clinics, instructing patients on family nutrition, a basic good diet, obesity, low hemoglobin, and other problems. Demonstrations of the various ways to incorporate skim milk powder in the daily diet are presented in clinics, and demonstrations of the use of surplus commodities are presented in the camps. The Extension Service home agent cooperates in teaching improved ways of carrying out basic household tasks, and in the demonstration of commodities. Both the nutritionist and the social worker assist families in obtaining eligibility certification for surplus commodities.

The nutritionist prepared a set of slides on the basic four food groups incorporating customary foods and surplus foods, and uses these in the clinics. She also prepared a simple guide in picture form for use with migrant families.

3. Colorado

Homemaking education for Colorado migrants is an important component of the total State migrant health plan. The home economics consultant has responsibility to plan, develop, promote and coordinate homemaking education with dental, nursing, environmental health, health education and social services for migrant farm families. She advises and assists migrants, local health departments, schools, communities and other agencies and organizations concerned with this or related programs.

Among many specific contributions made by the home economics consultant are the following:

a. Compiled a "Guide to Low Cost Meals" with consideration of cultural eating patterns and low income.
b. Prepared for classroom teachers a "Trial Guide for Nutrition Activities in the Classroom."
c. Compiled a "Guide for Menu Plans for Day Care Centers" for use in day care centers for migrant children.
d. Worked with the State Education Department to hire home economics personnel for migrant schools, to prepare a more extensive home economics curriculum that will meet migrant needs, and to give workshops on home economics for migrants.

The major contributions of the PHS Central and Regional Office staff working with the Migrant Health Program in the specific area of nutrition for migratory workers have been to prepare aids for local project workers and other interested persons, and to provide consultation to nurses, nutritionists and other project staff members on educational techniques.

Lists of nutrition films and leaflets have been prepared as part of listings of health education materials on other subjects (see attached). One of a series of films prepared by the Public Health Service is on the subject of preparation and storage of food in a migrant cabin. This was done in English with a Negro migrant cast and in both Spanish and English with a Mexican-American migrant cast.

To reduce the parasitic infestations which contribute to poor nutrition the Migrant Health Program is involved through local projects in a two-pronged effort: one to upgrade the living and working environment and the other to involve migrants in recognition of environmental health problems and learning how to deal with them. The major role of the PHS in this area, too, is to provide materials and consultation to project staff and other interested persons.

A comparison was made of the 256 "hunger" counties listed in "Hunger, U.S.A." with a listing of the 900 counties which have farm migrants leaving or coming into the area, or both, during each season. This comparison indicates that 75 of the "hunger" counties (29 percent) have 100 or more migrants at some period during each year. Of these, 58 (23 percent) are home-base counties where the migrant people merge with a larger, extremely needy, underemployed and unemployed rural population. Migrant health projects are currently operating in 18 of the 75 migrant "hunger" counties and of these, 14 are home-base counties.

This comparison provides a rough measure of the scope of the problem in its most acute form, especially in home-base areas. Actually, wherever migrants reside temporarily they are likely to encounter periods of underemployment and unemployment, and therefore in each of the 900 counties where migrants live temporarily there is a potential hunger problem whether or not these counties have been identified as "hunger" counties. Current USDA food distribution programs are extremely limited as a means of helping to meet this need.

In the 300 counties where migrant health projects are now operating, the project mechanism has potential for helping to meet nutritional needs more effectively than in the past. Extension of project services to additional counties and other methods would have to be found for the remaining 600 counties.

the usual channels, and to provide equipment for its preparation and storage. Such income support would need to be coupled with education regarding individual and family nutrition and budgeting, and food selection, purchasing, preparation, storage, and other items related to nutrition. This educational effort would need to be adapted to various age levels and ethnic groups represented in the migrant population, carried out with and through members of these groups in their own setting, and also carried out in schools, day care centers, teen-age organizations, and other group settings.

Research and demonstrations would need to accompany this educational effort in order to develop and improve methods of communication, motivation, and involvement; means of evaluating results; and basic knowledge about the nutritional status of various groups involved in the migratory farmworker population.

Lacking such an all-out approach, some suggestions could be readily implemented at relatively small cost. These might be carried out in the home-base counties also identified as "hunger" counties where the migrant-impact is greatest and where a migrant health project is currently in operation. Such an approach would have the advantage of starting where the problem is most acute. It would serve about one-fifth of the home-base population for several months of the year. (In these areas, obviously, a nutrition program should be directed to the needy rural population; not just to migrants)

Some of the activities that could be initiated very quickly include:

1. Strengthened effort to identify and treat nutritional problems among migrants, with the use of vitamins, iron and antibiotics to treat complications from severe nutritional problems.

2. Increase in planned effort to develop knowledge and leadership in the migrant group in defining problems related to nutrition including likes and dislikes for particular foods, developing practical ways to improve dietary and related homemaking and personal health practices, planning and conducting demonstrations using only the resources including facilities and equipment people have readily at hand, improving such facilities and equipment by readily feasible adaptations, and preparing informational materials.

3. Employment of indigenous aides to do a more intensive "outreach" and educational program with migrant families in their own homes, identifying possible diet deficiencies and planning with the families to meet them.

4. Coordination of effort of many groups along parallel lines--e.g., community action agencies, extension service, health agencies, educational programs, etc.

related health practices at beginning and end of specified periods.

6. Continuous assessment by persons having routine contacts with the migrants to determine improvements in nutritional status and practices, and to determine needed modifications in methods of communication and motivation.

7. Assurance of full use of foods available from USDA by establishing or strengthening working relationships to permit migrant health service projects to (a) act as "casefinders" for hungry people, (b) engage directly in the distribution of food where other distribution channels are inadequate or lacking, (c) develop and test new methods of assuring accessibility of food including changes in size of food package, in times and places where food is distributed, etc.

To apply the above suggestions to counties with an influx of migrants in addition to the .4 home-base areas identified as "hunger" counties in which migrant health projects now operate would obviously increase effort and costs. Application could be made quite readily in all 75 "hunger" counties having 100 or more migrants at some time during the year. It could also be made readily in other counties where hunger is a problem to the migrant population, although others may not be involved.

The following is an excerpt from a listing of health education materials in Spanish which is currently being prepared by the Public Health Service.

BUENA ALIMENTACION PARA LA BUENA SALUD (Good Food for Good Health)

Set of 7 leaflets; bi-lingual. Directed at general public.
Spanish-easy.
Available from: City of New York Department of Health.

CARNE PARA TODOS (Meat for All)

Pamphlet; directed at general public. Spanish-easy.
Available from: Departamento de Salud de Puerto Rico.

COMA DESAYUNO-EMPIECE EL DIA BIEN (Eat Breakfast - Start Every Day Right)

Folder; directed at general public. Spanish-moderately difficult.
Available from: City of New York Department of Health.

COMA ERUTA PARA BUENA SALUD (Eat Fruit for Good Health)

Leaflet; bi-lingual. Directed at general public. Spanish-easy.
Available from: Milwaukee City Health Department

COMA VEGETALES PARA BUENA SALUD (Eat Vegetables for Good Health)

Leaflet; bi-lingual. Directed at general public. Spanish-easy.
Available from: Milwaukee City Health Department.

COMIDA PARA SUBSTANCIA (Food for Fitness)

Folder; bi-lingual. Directed at general public. Spanish-easy.
Available from: Texas A & M University.

COMO ALIMENTAR BIEN A SU FAMILIA (How to Feed your Family Well)

Folder; bi-lingual. Directed at low income families.
Usable with migrants with sufficient skill in either language.
Available from: Indiana State Board of Health.

CONSUMA MAS HORTALIZAS (Eat More Vegetables)

Pamphlet; directed at general public. Spanish-moderately difficult.
Usable with Puerto Rican migrants.
Available from: Departamento de Salud de Puerto Rico.

Folder; directed at teenage boys. Spanish-easy.
Available from: New Jersey State Department of Health.

EL ALIMENTO ES IMPORTANTE PARA LA JOVENCITA (Food is Important for Teenage Girls and for Future Mothers)

Folder; directed at teenage girls. Spanish-easy.
Available from: New Jersey State Department of Health.

EL QUESO (The Cheese)

Leaflet; directed at housewives. Spanish-easy.
Available from: Departamento de Salud de Puerto Rico.

LA ALIMENTACION DEL ESCOLAR (Food for the School Child)

Pamphlet; directed at parents. Spanish-moderately difficult.
Available from: Departamento de Salud de Puerto Rico.

LA ESTRELLA DE LA BUENA ALIMENTACION (The Star of Good Eating)

Folder; directed at general public. Spanish-moderately difficult.
Available from: The New York City Health Department.

MEJORES MERIENDAS (Better Mid-Morning Meals)

Pamphlet; directed at general public. Spanish-easy.
Available from: Departamento de Salud de Puerto Rico.

UNA GUIA PARA COMER BIEN (A Guide for Good Eating)

Flier; directed at general public. Spanish-easy.
Available from: National Dairy Council.

USA LA LECHE EN ESTA FORMA (Ways of Using Milk)

Poster; directed at general public.
Available from: Departamento de Salud de Puerto Rico.

Note: Spanish language films suitable for use with migrant workers and families are difficult to find. Two in current use are:

PLANNING FOR GOOD EATING.

In Spanish and English.
Cartoon on importance of good nutrition.
Available from: Walt Disney Productions.

SAFE FOOD

Spanish and English versions.
Directed at migrants; stresses food storage and preparation