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*Migrant housing better, more health care*

# 1964 USPHS Grant Strengthens Migrant Labor Program

Even though much remains to be done, migrants were better housed and their health needs were more adequately met in Minnesota in 1964 than in any previous year. For the first time, it was possible for the Minnesota Department of Health to assign public health nurses and sanitarians to work directly with local physicians, migrant families, and community groups concerned with the welfare of the migrants.

The field project was the result of two grants from the U. S. Public Health Service: a $35,555 grant for the expansion and improvement of health services, in this case, public health nursing; and a $6,555 grant for activities relating to improvement of housing facilities and environmental health.

During the peak of the crop season, which in 1964 ran from approximately June 1 through July 25, there were about 6,000 migrant workers in Minnesota. An estimated 7,000 migrant workers came into the state during the entire growing season. With them came an additional 2,500 family dependents, some of whom were old enough to work in the fields.

In 1958 the state health department first was able to employ a camp sanitarian. However, since his duties included the inspection not only of migrant camps but also of industrial and children's camps, the sanitarian could inspect only about 100 migrant camps per year. Re-inspection of these camps was virtually impossible. Intensive work in migrant camps was done for the first time in 1963 as the result of a $5,924 grant from USPHS and the 1964 grant made it possible to continue with the work begun the previous year.

Appropriate state health department personnel in nursing and environmental health, as well as the project coordinator, provided the necessary supervision and coordination of the efforts of the field personnel. D. S. Fleming, M.D., director of the division of disease prevention and control, and F. L. Woodward, director of the division of environmental health, served as project directors.

There are few multiple-family camps in Minnesota. In the south central and northern counties, camps consist mostly of one-family dwellings, often deserted farm homes, separated from each other by a mile or more.

There are a total of 850 individual migrant labor camps in Minnesota. They are provided rent-free by the growers. Each is now identified on a spot map; however, scattered as they are, it would have been impossible to even locate them without direct assistance from the growers' associations and processing plants.

When the 1964 season was over, the three district sanitation inspectors had made initial inspections of the 850 camps and 160 re-inspections — a total of 1,010 camp visits during the 13 weeks of their employment. Each owner or camp operator had received a written report of findings for each first inspection. Individual conferences had been held with about 520 growers.

Prior to 1964 the state was unable to provide any direct assistance for public health nursing services for migrants. Most communities were without the professional services of health personnel other than those available locally on a volunteer basis. Two counties where migrants are employed even today are without a public health nursing service.

By the end of the 1964 season, the seven public health nurses had made 304 camp visits and 436 visits to individual families. About 175 persons had received individual counseling on specific health problems, and 149 individuals had been put in touch with physicians and other community resources that could help them.

With the cooperation of local physicians, the nurses helped to set up screening test procedures in boarding schools for migrant children, trained volunteers to assist in the screening programs, and did the necessary follow-up with the families of children whose test results showed the need for medical evaluation. In the

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Minnesota Department of Health staff for the migrant health project are (left to right) Alberta Wilson, chief, section of nursing; Evi Altschuler, assistant chief, section of nursing; D. S. Fleming, M.D., director of the project and director of the division of disease prevention and control; Judith Bieber, project coordinator; Marion Neilsen, supervisor of district nursing activities in the division of local health administration; and Charles Schneider, assistant director of the project and sanitarian in the division of environmental health.

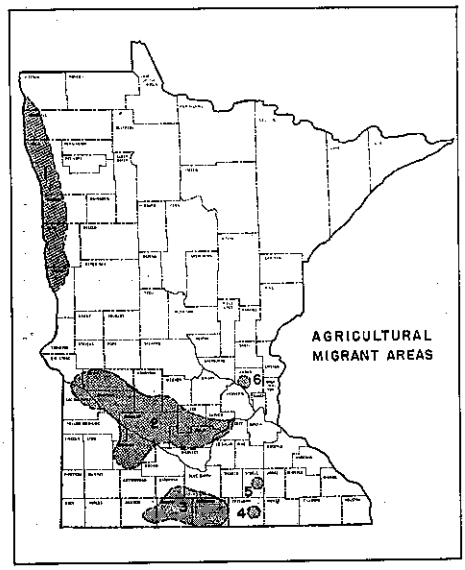
areas where mass tuberculosis chest x-rays were done, the nurses visited every family to pre-register them, did the follow-up visits, and made arrangements for large x-rays, with the cooperation of the local physicians and the volunteer migrant committee.

## HEALTH CONDITIONS AMONG MIGRANTS

Although many families appeared to be in excellent health, a household health survey conducted by the public health nurses revealed that 60 per cent of the families visited had had some kind of recent illness. Most of the illnesses were among children. Few acute conditions were recorded for adults.

In general, illnesses seen among the migrants were similar to those in the resident population, but the incidence of such illnesses tends to be higher than it is for the general population. Most migrants were reluctant to seek medical care except for emergencies.

The migrants tend to have a fatalistic attitude toward illness. A certain amount of illness is taken for granted, and they feel that it does not require any particular attention. No member of the family is considered ill unless the head of the family agrees that he is.




Migrant labor is needed in all or parts of 28 of Minnesota's 87 counties. Seventy per cent of the migrant camps are in the Red River Valley, an area that extends from the Canadian border along the North Dakota-Minnesota border to the northern boundary of South Dakota. Sugar beets are the main crop (1). Sugar beets also are grown in the south central and southern parts of the state, (2) and (3). Vegetables and some sugar beets are grown in Freeborn county (4). Vegetables for commercial canning and fresh produce sale are the main crop in Steele (5) and Anoka (6) counties. Migrants go from Minnesota to Illinois, Indiana, Iowa, Michigan, Ohio, and Wisconsin. Some of them go west to California and Washington.

### Child health

One public health nurse reported on a visit to a ten-month-old baby with diarrhea, high fever, and lung congestion. The father and mother were both out in the field, and a ten-year-old daughter was taking care of the baby and six other brothers and sisters, the oldest of which was seven. The three youngest had measles, and the two- and four-year-olds had diarrhea. The baby came down with measles four days later.

Thirty cases of communicable diseases were recorded among migrant children, including chicken pox, measles, mumps, and whooping cough. Fifty-eight cases of other acute conditions were noted, including infant diarrhea, eye and ear infections, pneumonia, respiratory system infections, and open sores. The 55 reported cases of chronic conditions involved mental retardation, orthopedic handicaps, anemia, and allergies as well as vision defects and hearing loss.

### Immunization status

A household survey revealed that approximately 60 per cent of the children had been immunized against diphtheria, tetanus, polio, and smallpox. However, the concept of preventive medicine is foreign to most of the migrants, and the reasons for immunization are obscure to them. To most of these parents, there is no difference between "baby shots," vaccination, or blood tests.

### Maternal health

Among women 15 years of age and over, there were 29 maternity cases, most of whom were visited by the public health nurses. In general, a large proportion of pregnant women in migrant families receive no prenatal care and get inadequate post partum care. Maternal mortality rates tend to be higher than in the general population.

### Tuberculosis control

While tuberculosis case rates among migrants as a whole are higher than the rates for the general population, 1964 findings indicate that the disease is well under control among the migrants who come to Minnesota.

Chest x-rays taken of 383 migrants in Steele and Freeborn counties revealed no new cases of tuberculosis. However, 2.7 per cent of the migrants required 14 x 17 x-rays, compared to only 1.2 per cent of the 187 local residents who also had x-rays taken at the time the mobile x-ray machine furnished by the Minnesota Tuberculosis and Health Association was stationed at the three migrant camps in those counties.

The absence of new cases in part reflects the value of screening programs, case-finding, and follow-up in recent years carried on by the states where migrant workers are employed. On a statewide basis, 60 per cent of the migrants who had direct contact with the Minnesota nurses reported having had a Mantoux test or a chest x-ray in the last year. However, as long as most adults and many children have positive Mantoux tests, it will continue to be essential to carry on intensive tuberculosis control measures in this group of people.

### Hearing and vision

Public health nurses cooperated with local physicians and school personnel at St. Joseph's Migrant School, Moorhead, and at Cathedral and Polk County migrant schools, Crookston, in hearing and vision screening of the estimated 200 children in their classrooms. Fourteen children with suspected hearing deficiencies and 23 with possible visual deficiencies were detected.

Some of the children with vision difficulties were aware of the condition and had been tested elsewhere. Nurses got the school staff in touch with an organization with an eyeglass service for medically indigent persons in the hopes that this organization would be able to help these children to get the glasses they needed.

The nurses also visited the families of each child with suspected hearing or vision loss and made appropriate referrals to local physicians.

### Nutritional status

Because it is expensive, meat is a scarcity in the migrant's diet. Tortillas are the staple of the family diet. The diets may not be adequate for optimum nutritional balance, but acute malnutrition is not a general health problem. However, such conditions do exist.

Two children, two and three years of age, who were unable to walk were seen by one nurse. Hospitalization, paid for by the county welfare board, indicated that their inability to walk was probably due to dietary deficiencies, since complete medical evaluations revealed no other pertinent findings. When the family left the state, the field nurse for the Crippled Children Services made appropriate arrangements for follow-up with that service in the state to which the family was going.

In a few instances, migrants arrived completely without funds. One such family scavenged the dump across from their house for food until the public health nurse put them in touch with government surplus foods available through the county welfare board. A church group with a



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migrant clothing service gave the family the clothing it needed.

One young boy was in such poor physical condition that a tentative diagnosis of tuberculosis was made when he was first seen by a physician. Further medical evaluation ruled out tuberculosis. The final medical diagnosis was that of severe malnutrition.

**Personal health record**

For a number of years the U. S. Public Health Service has encouraged the use of a personal health record card for the migrant families to take with them as they move from state to state. This method of transmitting health information is intended to coordinate what is done in one area with what is done in every other state to which the migrant travels. To the extent that these cards are kept up to date for each member of the family, physicians have a record of previous clinical conditions, obstetrical dates, and immunization status.

Although these cards have been available through the Minnesota Department of Health since 1961, limited use was made of them in the absence of a state-

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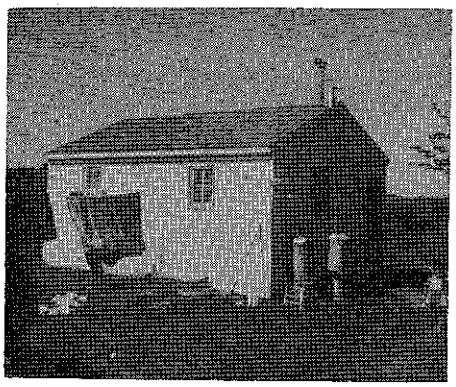
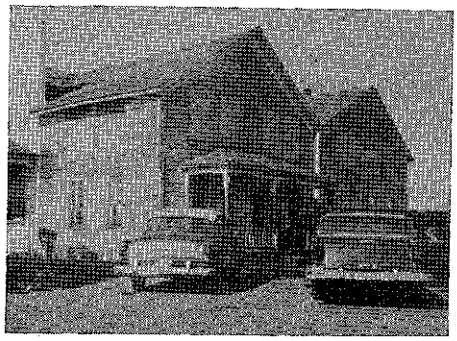


Pictures taken by Minnesota Department of Health staff in 1964 show the difference between good and bad housing in migrant camps. The house above is the one-room home of six persons. Only three rooms in the house below can even be lived in. They house a family of ten. The rest of the house is used for grain storage.



# Communities Help Migrant Face Uncertain Future

Most of the Minnesota migrants are of Mexican descent, and they are citizens of this country. Texas, the home state for almost all of them, has an estimated 125,000 migrant laborers; in 1963, 91,565 of them migrated to 32 states.

Most of them become migrant laborers because they are unable to find steady work in their own community. Even at home they are seldom closely associated with the community and face many problems they do not understand and are not prepared to meet. The needs of the migrants are great while at home but these problems and needs are multiplied while they are on the road.

Local communities in Minnesota have always shown a concern for the health and welfare of the migrants among them and have done much to help.

In certain areas, growers established a fund from which migrants' unusual medical expenses could be paid; other growers carried Workmen's Compensation.

Over the years, the concern of some of the state growers led to important housing improvements. Several growers constructed new housing facilities for migrants. Others made improvements for water supply, laundry, toilet, waste, and garbage disposal facilities.

Organized maternal and child health services in a few areas are other examples of coordinated community effort involving a partnership between local medical societies and individual physicians, growers, community hospitals, and local church groups.

In some areas of the state, school authorities are proud to have achieved almost 100 per cent attendance of school-age children whose families came to Minnesota before the end of a school year. In some areas, county migrant committees and local church groups have maintained summer schools for many years to offset time lost during the school year.

State agencies, particularly the state health department, the Minnesota State Employment Service, the Minnesota Department of Public Welfare, and the Minnesota Department of Education, have given all possible assistance to these community-based activities.

What was accomplished in 1964 was possible only because of the active support and cooperation of many groups and persons at state and local levels. This statewide coordination of all community efforts and the provision of certain health services not previously available are the ingredients missing in what has been done in recent years.

However, to date most of what has been accomplished has been a process of doing for rather than with the migrant. Group involvement of these itinerant workers is difficult to achieve. In order to be effective, any method must be within the framework of their culture.

Sanitarians found that where housing was involved, heads of families or crew leaders were the key persons because of their position of authority in the camp and with the other members of their families. Where health was involved, the head of the family determined whether a member of his family was ill and, if he was, what should be done about it.

A basic obstacle in getting the migrant to take greater responsibility for his own health and that of his family is his lack of knowledge and understanding. His background and education are such that he does not relate housing deficiencies to disease and he has little concept of preventive medicine. Essentially, the problem is one of education.

All that was needed in many instances to change the way of living of the few migrants who were doing a poor job of housekeeping was a simple explanation of the need for good housekeeping and a demonstration of the correct way to dispose of garbage or to store food.

The attitude of the grower is an intangible factor in the behavior of the migrants. In one camp the workers stated that the only time the operator talked to them was when he found fault with them; these workers were less productive than migrants in nearby camps where housing and communications were better. At midseason this operator had one of the poorer sugar beet fields in the area.

In contrast to this situation, one grower planted one and a half acres of sweet corn for the migrants to care for on their own time. The migrants earned $200 from the sale of the sweet corn which they had taken care of, harvested, and marketed. This operator's fields were among the finest in the area.

Problems relating to breakdowns in communications and lack of knowledge or understanding that lead to changes in behavior are not unique to the migrants. They are found in every segment of the population, but they are intensified in the culture of the migrants because of the language barrier and the migrants' socio-economic level.

In time, the gap between their standards of living and that more common to modern life will be bridged, but the tempo of living today is such that man cannot wait for time alone to do it. Every community effort in behalf of these migrants in this state and elsewhere contributes to this basic goal.

wide coordinated migrant health program. In 1964 approximately 5,000 of these folders were distributed to local physicians and to migrant families. Migrants were encouraged to carry the cards with them and to see that they were brought up to date each time a member of the family had occasion to see a physician.

### CAMP FACILITIES

Findings in 1963 and 1964 reflect the value of a sustained, organized program. At the end of the 1963 season, 22 per cent (188) of the 811 camps inspected were in compliance with the regulations of the state board of health for migrant labor camps. At the end of the 1964 season, 33 per cent (284) of the 850 camps inspected met the standards and approximately 100 camp operators planned improvements for the 1965 season.

Even so, only one camp in five had no deficiencies. Approximately 20 per cent of the housing facilities for migrant families had major deficiencies, and another 45 per cent were in need of some improvements to meet minimum standards. About half the camps have running water, either inside the living quarters or just outside. About one camp in ten has an indoor toilet. Most of the bathing facilities in the camps are the old-fashioned wash tubs.

While no studies were made to relate health to insanitary conditions in the camps, sanitation problems could have been responsible for several cases of diarrhea among families. Large fly populations, inadequate screening, insanitary privies, and improper disposal of garbage and refuse could have contributed to intestinal illnesses. Poison ivy growing in abundance around some camps resulted in some cases of poison ivy. Injuries occurred among both children and adults in camps where there were obvious safety hazards.

Most of the violations of state regulations for migrant labor camps had to do with improper sewage and excreta disposal; inadequate disposal of garbage and refuse; absence of screens or screens in need of repair; camp site violations, largely safety hazards and excessive undergrowth; and buildings in disrepair. All of these deficiencies have health and safety implications. However, the percentage of violations in each category in relation to the number of camps inspected was lower in 1964 than in 1963.

Of the 811 camp investigations in 1963, 62 per cent of the violations (614) had to do with inadequate screening. This deficiency accounted for only 29 per cent of the violations (248) noted in 850 initial camp inspections in 1964.

Violations due to the condition of buildings fell from 19 per cent (156 in 811 camps) in 1963 to 8 per cent (70 violations in 850 camps) in 1964.

Adequate sewage and excreta disposal remains a major problem, but progress was noted even in this category. In 1963, 75 per cent (609) of the violations noted in 811 camps had to do with insanitary privies, privies in disrepair or in need of new pits. In 1964, 69 per cent of the violations (585) noted in 850 camps were of this kind.

Poor housekeeping on the part of the migrants accounted for some of the reported violations. In 1963 there were 98 reported violations having to do with the cleanliness of the family camp; 24 such violations were reported in 1964.

Although acceptable housing facilities are desirable and necessary for the protection of the health of migrants and of the community, the short period of time that the camps are occupied discourages many growers from making improvements in housing conditions.

Although the majority of migrants have few basic skills in carpentry, painting, and general repair, the sanitarians found that with proper encouragement many migrants were willing to do maintenance or repair work when bad weather kept them out of the fields. Few of them would do it on their own initiative but, when camp operators initiated such projects, most of the migrants were willing to do their share.

### TRENDS IN EMPLOYMENT OF MIGRANTS

Each year, fewer migrants are needed in Minnesota. Increased mechanization is one factor. Another factor is the employment of high school students from local communities, a work program initiated by the Minnesota Department of Employment Security with the cooperation of the local beet sugar companies.

However, in 1964 severe weed conditions hampered the efforts of some growers to cultivate and thin beets entirely by machine, and high school boys do not always do as good a job at stoop labor as the migrants. Migrants frequently put in 11 hours a day, seven days a week. Their take-home pay averages $85 to $90 a week.

Eventually under normal weather and weed conditions, increased mechanization may make it possible to rely entirely on local high school students for all field work. One canning company, which in 1963 employed 126 migrants, employed no migrant workers in 1964 because of complete mechanization of its operation.

For the most part, mechanization requires men with greater mechanical skills than those possessed by most migrants. Too, growers would prefer workers who live in their own homes, since this eliminates the need for providing housing.

However, as long as migrant workers are needed in the production and harvesting of crops, housing expenses for them are as much a part of the cost of growing crops as those incurred for fertilizer, weedicides or pesticides, and farm equipment. Good housing attracts higher calibre workers and the migrant's health and welfare are directly related to his productivity in the field.

Beyond the economic benefits to be gained, there are moral and social obligations to these workers which must be recognized by the nation, by the states whose agricultural economy depends in part on their efforts, and by the communities in which they make their homes.

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