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Family, Culture, and Health Practices Among Migrant Farmworkers

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Migrant farmworkers and their families have restricted access to health and human services because of their frequent relocation between states, language and cultural barriers, and limited economic and political resources. Living and working in substandard environments, these families are at greater risk for developing chronic and communicable disease. In an assessment of health patterns among 225 migrant workers and their families, using personal observations, unstructured interviews, and individual and state health records, children's immunizations were found to be current, but dental caries and head lice were epidemic. Among adults, almost one third tested positive for tuberculosis exposure. Urinary tract infections were the most common health problem among women. Primary and secondary prevention were almost nonexistent because funds for these services were not readily available. The patriarchal system contributes to these problems by limiting access to family-health and social service needs. Although providing comprehensive health care to migrant communities presents unique challenges, nurses can demonstrate their effectiveness in reducing morbidity through strategic interventions and alternative uses of health delivery systems.

Health practices among migrant farmworkers represent a challenge to health care providers due to the magnitude of environmental stressors that compromise this aggregate's economic and health care resources. Migrant farmwork is normally multigenerational, following a family history of working in the fields and often returning to the same locations each year (Schneider, 1986). Under the duress of poor housing, limited sanitation facilities, inadequate diet, and substandard health care, migrant farmworkers and their families are at greater risk for communicable and chronic health problems than the U.S. population (Dever, 1991). Furthermore, the adverse environmental, social, and economic circumstances associated with the life-

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style of migrant farm families suggest a high risk for domestic violence in this group (Koroscik & Rodriguez, 1994; National Migrant Resource Program, 1990). The purpose of this article is to describe health patterns, family systems, and culture among a group of migrant farmworkers and to assess the impact of these findings on nursing practice.

SETTING

Beginning in late May of each year, migrant farmworkers and their families move north from Florida into south-central Georgia to pick bell peppers, squash, and cucumbers. A majority of these workers originally come from the southern area of the United States via Mexico and Texas and move to the northern states as crops ripen and become available for harvest. A crew chief, who acts as a middleman between the migrant worker and the farmer, alerts the migrants to available positions, and the workers and their families relocate in groups. They are often required to drive day and night to move from one camp to another as crops ripen. The cycle repeats itself annually, with workers and their families bringing only the most essential possessions in aging cars, vans, and trucks. For children of these families, these conditions directly interfere with their educational processes and social development (Diaz, Trotter, & Rivera, 1989). Occasionally, van-loads of "solos"—single men traveling without families—embark on this migratory journey. Their status is even more precarious because their family support systems are absent.

Living predominately in rent-free trailers furnished by the farmer, the workers harvest crops at $.40 per 5-gallon bushel. On a good day, workers can make up to $100.00, but rain, poor harvest, injuries, and disease can prevent maximum earnings. They average $30.00 to $60.00, based on a 4- to 6-hr workday. The abbreviated work schedule is due to both the intense weather and the inconsistent ripening of crops. Both women and men work in the fields, although women with children may either remain at home or arrange for a sitter. The sitter, who earns $5.00 per day per child, is normally a teenage girl or young mother. Because family vehicles are used to transport the workers to the fields, those people left in the camp are generally without transportation.

RESEARCH DESIGN

Employing unstructured interviews, personal observations, and individual and state health records, data were collected for 225 men, women, and children in five migrant health camps in southern Georgia. This research was compiled over a 2-week period by senior baccalaureate nursing students as part of their community health nursing rotation. Assessment variables included status of immunizations, occupation-related health factors, barriers to health access, and issues related specifically to women's and children's health. Confidentiality of data was secured in compliance

with the university Institutional Review Board and the state's district health office. Analysis of the findings and a description of the interventions follow.

Immunizations

Preventive health practices are an indication of both risk and control. In this study, immunizations assessed included diphtheria-tetanus-pertussis, measles-mumps-rubella (MMR), *Hemophilus influenza* Type B (HiB), polio, and tetanus. All of the children under 17 ($n = 91$) had immunization records, and of this group, 95% were adequately immunized. The most frequent missing immunization was the last MMR and HiB series, which was subsequently provided to the children free of charge, following state guidelines. The majority of prior immunizations had been furnished to the children by the public health department of their permanent residence in Florida.

The vast majority of adults ($n = 134$) did not have health or immunization records available. Although tetanus boosters were offered, only 17 adults accepted the immunizations. Convincing the crew chief to receive the first injection encouraged some of the other workers to overcome their reluctance. To maximize participation, the tetanus booster was offered at no cost in camp during lunch breaks and in the fields while people were working. Many stated they had received the booster within the past 10 years, although this could not be confirmed. Others stated they did not want the injection due to the possibility of a sore arm, which would interfere with picking crops. Foreign-born migrant workers may never have received an adequate primary series vaccine against tetanus, and thus this booster may have been insufficient protection against the disease.

Tb remains a major health problem among migrant farmworkers (Centers for Disease Control, 1992). Workers tend to live in close proximity to one another during the harvest period, often with two or three families sharing one single-wide trailer. At one camp, 16 men slept in a single trailer. Sanitary facilities are strained under these conditions, and transmission of disease—particularly tuberculosis (Tb)—became inevitable.

Of the 126 adults who requested tuberculin screening, 39 had positive purified-protein derivative (PPD) skin reactions greater than 10 mm. None of those screened were under prophylactic treatment. This finding suggests a higher risk of exposure in the migrant worker community than is prevalent in the general population.

Although Tb screening is necessary in the migrant community because of the high prevalence of the disease, essential follow-up procedures and treatment must also be available for those with positive skin reactions. In this study, inaccessibility to the state Tb chest x-ray van delayed confirmation of active cases, and financial constraints further prohibited prophylactic treatment. Furthermore, those with a positive PPD often relocated before the state-run mobile unit arrived. Because physical signs and symptoms were generally absent, the infected person often did not believe the infection was present, thus adversely affecting compliance with treat-

ment. Understanding the need for lengthy treatment when no signs or symptoms were apparent was further aggravated by language and cultural barriers.

Although court-ordered compliance is required for active Tb cases, it is often an ineffective process for this segment of the population due to the workers' migratory patterns and the absence of a nationwide tracking system. Because of the financial cost to the state and the problems with compliance already inherent in the migrant population, those diagnosed with active Tb were provided with only a 1-month supply of medication.

Occupational Health

Although migrant workers may suffer from exposure to pesticides and chemicals, extreme heat and dehydration, unsanitary and unsafe working and living conditions, and on-the-job injuries, health-resource availability and use are low among this group compared to the general population (Sakala, 1988). Monitoring labor conditions is a function of several state and governmental agencies, including the Occupational Safety and Health Administration, the Department of Labor, and the Department of Agriculture. However, specific barriers, such as job loss, often prohibit the migrant worker from discussing working conditions or reporting minor injuries. Thus, an accurate determination of the incidence of occupational injuries among migrant workers does not exist.

In this setting, crew leaders affirmed that injuries were few and were treated promptly and effectively, although the only visible evidence of health care supplies were basic first aid kits. Minor injuries received superficial treatment in the field from either fellow workers or the crew chief, although each crew chief had access to a cellular phone to be used in case of emergencies. Non-emergency and chronic health conditions, however, received minimal attention and were the responsibility of the worker. Leaving the fields resulted in a loss of pay because workers were compensated on the amount of crops picked. Farmers were not required to pay for health insurance or worker's compensation.

Barriers to Health Access

The multiple and complex barriers to accessible health care identified in this study include (a) dissimilarities in language and culture, (b) low levels of income, (c) powerlessness in the political arena, and (d) limitations of health resources. In south-central Georgia, there were no paid bilingual staff members at the hospital, the Department of Family and Children's Services, or the sheriff's department. However, the primary care center provided bilingual workers who not only visited the camps, but advocated for the migrant workers with local and state authorities as well. Additionally, minimal educational levels further hindered workers' understanding of health maintenance and restoration concepts. Finally, migrant populations relocate constantly, limiting the determination of specific health patterns and indices.

Most of the school-age children in the camps spoke English and Spanish fluently,

but the adults generally had limited proficiency in speaking and understanding English. Although certain reading materials were available in Spanish, most were poorly translated.

The average annual income for migrant families in this assessment was $7,000 per year, well below national poverty levels. In the migrant families interviewed, only 5 were receiving Medicaid, 9 were receiving food stamps, and 10 were enrolled in the Women, Infants and Children (WIC) program. Identified barriers to receiving food stamps included the waiting period, the cost and inconvenience of renting a permanent post office box, and the restricted hours during which the agency was open for applications. The agency's office hours conflicted with the migrant workers' availability of personal transportation and breaks away from the field. Many of the migrant workers stated they were unwilling to use the system because they could not afford the loss of a day's pay. In addition, the migrant's inherent suspicion of strangers can impede communicating basic needs to health and social service agencies.

Many migrant families reside in their state of legal residence fewer than 4 months each year. The number of illegal residents in this setting was minimal, but because the population moved among several communities, the workers had little voice and limited influence in the local political decision-making process. Consequently, few avenues were available for changing working and living conditions, which in some cases could be compared to those in Third World countries. Moreover, state and federal agencies were severely understaffed and unable to provide adequate enforcement of health regulations and labor laws.

Access to health agencies can be a formidable barrier for migrant workers. Office hours for these agencies were normally 9:00 a.m. to 5:00 p.m. Monday through Friday, which parallels the time migrants are in the fields. Unfortunately, the limited amount of available professionals in the area also prohibits taking health care to the migrants. When the nurse practitioner from the clinic visited the camps, then no one was available to see clients at the primary health center. Thus, the emergency room at the community hospital was considered the most accessible and, unfortunately, the most expensive health care facility for this population.

If the migrant families accessed available health services, the primary care center did provide well child examinations, hearing and vision screenings, and immunizations on a sliding-scale fee basis. In addition, prenatal and family planning services were available from the public health department, but routine dental care was essentially nonexistent, although several dentists in the area did offer emergency services for a reduced fee.

Women and Children's Health

Hispanic migrant culture is patriarchal, with men playing the dominant role in decision making and income dispersement. Hence, money was available for alcoholic beverages and snacks but not necessarily for nutritious food, dental care, and over-the-counter medications.

Women in this culture frequently marry at an early age and often have begun to

bear children by the time they are 13 to 17 years old. Because of the transitory nature of the work, continuous prenatal care is usually difficult to attain. Although no pregnant women were observed in the five migrant farm camps involved, progress is occurring with the implementation of the "Right from the Start" Medicaid program.

Due to their constant relocation, children of migrant workers received fragmented health care. Many of these children subsequently withdrew from the educational system, and, equipped with little more than a sixth-grade education, have limited future job opportunities. Thus, they are forced into the repetitious migratory patterns of their ancestors.

Health problems most frequently found in women and children during this survey included nutritional deficiencies, urinary tract infections, diabetes, hypertension, dental caries, skin infections, and head lice. A 3-day screening of hemoglobin in children at a migrant summer-school program revealed that 24% of the children screened ($n = 46$) fell below WIC standards. Part of this deficiency may be attributed to the discarding of iron skillets and kettles, which were a rich source of minerals. The more portable, lightweight, and modern aluminum pans represent affluence.

Among migrant women, urinary tract infections were frequently encountered. Due to the demanding working conditions and the absence of facilities in the fields, many of the women stated that they did not have the time or the opportunity to urinate when needed. Overcrowding in the camps further hindered hygienic practices, and the work in the hot Georgia sun perpetuated dehydration.

Diabetes and hypertension were exacerbated by poor diet and high levels of stress in the camps and fields. Funds for treatment of chronic health conditions were very limited, and families did not have ready access to or knowledge of preventive or routine health measures. There was no access to urine dipsticks or glucometers, and knowledge of appropriate foot care and opportunities to practice hygienic measures for skin integrity were minimal.

Dental caries were epidemic within this community. Almost all the children screened had dental caries and plaque accumulations, and a majority of the adults had missing and decayed teeth. Refined sugars and soft drinks are not normally a part of a traditional Mexican diet, but migrant children are frequently exposed to these foods in the migratory life cycle. Furthermore, most of the families did not own a single toothbrush, and routine maintenance and preventive dental care was either unavailable or unsought. As a general rule, visits to a dental care provider were sought only when the pain became severe.

Another frequently observed condition among the migrant children was the presence of head lice and the picking of nits. Barriers to the effective treatment of this condition included cost, the time and work considerations of the parents, and the lack of a perceived need for treatment. Although funds for prescription drugs were allocated by the primary care center, some families did not believe the situation warranted spending their dollars for medications to treat head lice.

DISCUSSION

Based on the assessment data in this study, the community health nurse who attempts to provide quality care to migrant communities will find (a) multiple health problems and minimal resources, (b) limited accessibility to other health professionals, and (c) multigenerational and interfamilial factors that create a difficult framework to change. Because of their distrust of outsiders, migrant workers may perceive health providers as having policing powers. Consequently, a reluctance to respond to questions has become an integral part of their relationship with health providers. Even when distrust is not a factor, the health care professional must be aware that for the migrant, each minute away from the fields translates into lost income. With almost no advance knowledge of how long or when the worker will be in the fields, preparation for other activities may be restricted.

Health care providers should be more cognizant of differing cultural values and should employ every effort to bridge this gap with bilingual outreach workers from the migrant community. Instituting a Spanish language requirement with multicultural sensitivity training for those health professionals who work with migrants could enhance their trust-building ability as well as their skills in communicating with this population. In addition, user-friendly services, such as mobile units or extended health center hours, would increase accessibility to health care, although the perceived priorities of the migrant workers may still limit the effectiveness of some interventions. Integrating the farmer or employer into the health and social concerns of the migrant families may also be helpful. Due to their own financial constraints, farmers traditionally have not been consulted concerning migrant health care. However, collective discussions during program planning involving the farmers, local health and human services agencies, and crew chiefs from each camp could positively impact the quality of life of the migrant family. They could also increase utilization of primary (rather than secondary and tertiary) services.

Continued investigation to improve the health care of migrant farmworkers and their families is needed. This commitment will necessitate a prolonged period of assessment, intervention, and evaluation—areas in which community health nurses excel. Increased federal funding for migrant health projects is essential to develop outreach and primary care services. Regulations that limit reimbursement for dental and eye examinations, mammograms, and preventive health care should be reevaluated.

In this assessment, migrant farmworkers traveled significant distances to avail themselves of the services of the primary care center rather than visit the public health department which was much closer to both the camps and fields. Further reduction of the need for secondary and tertiary interventions was accomplished through efforts of a nurse practitioner, the initiation of weekend health-education classes, and the hiring of a bilingual health care worker from the migrant farm community.

When exposed to this unique population, nursing and allied health students can provide high-quality health care to migrant workers and their families. In addition,

the development of community partnerships, involving the farmer, local health and human service organizations, and migrant farm families, can be instrumental in reducing morbidity and increasing quality of life. Providing quality health care, reasonable living accommodations, and opportunities for personal growth for the migrant worker and his family can be attained when communities unite to reach a common goal.

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