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Migrant Farmworkers' Health Issues

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It is an honor to present some of the issues facing migrant farmworkers in the area of health care delivery. As the Chair-Elect of the Migrant Clinicians Network, I represent the nurses, doctors, dentists and other frontline providers caring for migrant and seasonal farmworkers and their families in remote, rural areas.

Farmworkers are wonderful people. They are smart and hardworking and they are survivors, accustomed to doing without or receiving very little. Sadly they have to be, because we can do so little for them with what we have.

Between 3.5 and 5 million men, women and children toil as migrant and seasonal farmworkers. From a health care perspective they are among the most vulnerable, high risk and hard to reach individuals in the nation. A combination of stringent working conditions, inadequate or nonexistent housing, poverty, poor nutrition and lack of access to medical care and basic health care information has resulted in farmworkers having the highest infectious disease rate in the United States, a staggering rate of tuberculosis infection, high rate of chronic diseases, and a risk for HIV that is ten times the national average (Dever, 1991; Castro and Narkunas, 1989).

More than 85 percent of the migrant and seasonal farm working population is estimated to consist of ethnic minorities (Mines, *et al.*, 1991). The majority of farmworkers are U.S. citizens, but many of them are at varying levels of acculturation. Along the east coast there are Latinos of Mexican-American, Central-American, Cuban and Puerto Rican background, as well as African Americans, Creole-speaking Haitians, Jamaicans, among others. In the central United States, the majority of migrant farmworkers are Latinos from the U.S.-Mexico border regions; on the west coast Mexican Hispanics predominate.

Farmworkers provide temporary labor during peak periods of agriculture which is absolutely essential to food production. The work they perform is intense, but it is of short duration and is insufficient to support a

permanent year-round workforce. Farmworkers must move frequently in order to stay employed. Because of this, they are often excluded from the protection of our social benefit system. Enrollment and retention procedures for benefits such as Medicaid are designed for populations which remain in one location. States have the discretion in the administration of their Medicaid programs, with the result that they have differing eligibility, certification, enrollment and benefit structures. It is estimated that 90 percent of farmworkers meet the economic eligibility requirements for Medicaid, and even after accounting for other possible disqualifying factors at least 60 percent are wholly eligible, but fewer than 12 percent receive any type of health benefits (Larson, *et al.*, 1992). Technically, mechanisms are in place to ensure eligible farmworkers access to health care under Medicaid, but it has not happened. In any health care reform initiative, we must strive to increase the number of farmworkers who have access to benefits, and those benefits must be portable and universal throughout the system (Migrant Clinician's Network, 1993).

Most migrant farmworkers earn annual incomes well below the poverty level, in spite of the fact that every able-bodied member of the family, young and old, works (Dever, 1991). Anything that interferes with work is avoided, delayed as long as possible, or dealt with in the most cursory fashion. There is no sick leave in the fields, and farmworkers who miss a day of work may lose their jobs.

There is great cause to worry about the health and well-being of migrant and seasonal farmworkers and their families.

In some areas as many as 78 percent of farmworkers, both adults and children, suffer from parasitic infections, mostly water-borne (Ciesielski, *et al.*, 1991). This figure strongly contrasts with the national average of 2–3 percent. Farmworkers observed in one study were found to be 300 times more likely than the general population to develop infectious hepatitis (Wilk, 1986). Communicable diseases such as hepatitis, tuberculosis and other serious viral and bacterial illnesses are unusually prevalent, and the rate of reinfection is particularly high due to cramped and unsanitary living conditions.

The health status of migrant women and young children is particularly disturbing. Approximately 43 percent of pregnant migrant women seek prenatal care in the first trimester, compared to 76 percent nationally (Puente, 1988). Farmworker women tend to be young, undernourished, exposed to toxins during pregnancy, and have short spacing between pregnancies (Littlefield and Stout, 1988; Hendrickson, 1990; Larson *et al.*, 1992). The absence or postponement of prenatal care often results in low birth weight, the leading cause of infant morbidity and mortality. Data from Colorado's Migrant Health Program over a four-year average reported a shocking low birth weight rate of 44.6 per 1,000 live births (D. Horton, 1992, Colorado Department of Health, Migrant Health Program, personal communication). Just a little over a year ago, a Brownsville, Texas newspaper

reported the occurrence of neural tube defects at six times the normal U.S. incidence. Of the seventeen babies, half of the parents had been farmworkers or employed in factory work where they might have come in contact with toxic substances (*Laredo Morning Times*, 1992).

Despite the efforts of the Migrant Head Start Program, childcare facilities for farmworkers are scarce. Many farmworkers have no choice but to take their young children with them to the fields or leave them unattended at the labor camp. Accidents including falls, burns, poisoning and drowning are the second most serious health problem following infectious diseases for this age group (Dever, 1991). Farmworker children are less likely to receive the standard childhood immunizations at the appropriate age so therefore suffer higher rates of preventable infectious diseases, such as whooping cough, and measles. Ranges as high as 47 percent to 60 percent of migrant children examined have at least one, and average three, untreated dental caries (Call, *et al.*, 1987; Koday, *et al.*, 1990).

Federal standards set 12 years of age as the legal age limit to do farm work; however, exemptions for 10- and 11-year old children exist, and numerous farmworker children can be found working in the fields (Wilk, 1986). Migrant students switch schools an average of 3–9 times per school year. Only 50 percent of migrant students who enter elementary school will go on to high school.

The resurgence of tuberculosis, and the emergence of multi-drug resistant TB in the United States, has been making headlines. After declining for nearly a century, incidence of tuberculosis has been rising since 1985, and it is rising most rapidly among young adults. A recent study conducted by the Center for Disease Control (CDC) indicated that as many as 44 percent of migrant farmworkers test positive on tuberculin skin tests (CDC, 1986). In North Carolina's migrant labor camps, the rate among African Americans is 3,600 cases per 100,000; more than ten times the case rate in sub-Saharan Africa, where TB is still a leading killer (Ciesielski, 1991). While a healthy TB carrier has a one-in-ten lifetime odds of illness, an immuno-compromised TB carrier develops active, contagious disease at a rate of 10 percent a year (CDC, 1992).

Many migrant farmworkers move an average of eleven to thirteen times a year to find work. Unfamiliarity with an area, poverty and the inability to seek services during regular working hours add to the difficulty farmworkers encounter when trying to access health care. The unbroken regimen of treatment that is necessary for TB is very difficult for farmworkers to maintain. The CDC recommends a six-month four-drug regimen for farmworkers with uncomplicated pulmonary TB. Isoniazid, Rifampin, Pyrazinamide, and Ethambutol are recommended for two months. For the remaining four months, Isoniazid and Rifampin should be administered (CDC, 1992). Successful treatment of a migrant farmworker with active TB will require a case management approach that may extend over a wide

geographic region. Failure to control TB in the farmworker population will mean failure to control TB in the nation.

The migrant farmworker population is relatively unsophisticated. Low literacy levels, limited ability to speak English, and the multiple stressors impacting on life as a farmworker makes this population vulnerable to mental health problems and substance abuse.

Ethnic and cultural backgrounds of farmworkers may inadvertently encourage high risk activities or obscure recognition of high risk behavior. For instance, Latino populations share needles to inject vitamins or medications obtainable in their home country (National Migration Resource Program, 1987). Some cultures encourage men to engage in sex with multiple partners. Migrant health clinicians are keenly aware of the availability of drugs and prostitutes to farmworkers, especially at the single male labor camps. Due to lack of information, they are at risk for unsafe behaviors which expose them to the threat of HIV infection and AIDS. A recent survey of knowledge and behavior reported as high as 52 percent of farmworkers did not know AIDS could be transmitted heterosexually (Vasilion, 1992). Because of these facts, the problem of HIV among migrant farmworkers is growing. A 1987 CDC study indiaged that 0.5 percent of farmworkers tested positive for HIV (CDC, 1988). A 1992 study determined that the percentage of farmworkers testing positive for HIV is now 5 percent, ten times greater than it was five years ago (Lyons, 1992). Last summer, Keystone Migrant Health Program in Chambersburg, Pennsylvania reported that 6.8 percent of farmworkers tested positive for HIV and 9.7 percent were positive for syphilis. Two thirds of this population reported never using condoms and 48 percent had more than three sexual partners in the past five years (Pennsylvania Department of Health, 1991).

In an effort to provide migrant farmworkers with HIV, TB and other health care information that is culturally appropriate, the Migrant Clinician's Network developed guidelines for designing a plan of care. These guidelines are referred to as CLEF, an acronym which stands for Cultural Linguistic Environment Education and Follow-up. These are considerations that can have a profound effect on the health outcomes of the farmworker population (Migrant Clinician's Network, 1988).

A health care provider must be able to determine the cultural background of the client to be able to respond to possible home remedies or other traditional healing practices. To communicate effectively, the client's preferred language must be used. The immediate environment where the client resides and works must be assessed, as well as the level of education and literacy. An understanding that the migrant farmworker may leave an area tomorrow makes it imperative to establish a follow-up plan at each visit. CLEF is a process which allows clinicians to make care appropriate and acceptable to clients from diverse cultural backgrounds and adverse living circumstances. These are necessary considerations and activities if migrant farmworkers are to have access to the health care system.

Migrant health center staff have long realized that outreach programs are fundamental to providing services to farmworkers. One of the most successful concepts developed to provide culturally appropriate and acceptable outreach to migrant farmworkers has been through training of migrant lay health promoters (Grube Robinson, 1990; Watkins, *et al.*, 1990; Castanares, 1990; Meister and de Zapien, 1990). The concept begins with recruiting natural leaders or helpers within the migrant community, women or men who are sought out for their wisdom and empathy. Basically, lay health promoter programs provide a selected group of farmworkers with basic health care information and leadership skills. Because the lay health promoter embodies the same language, culture and life situation, health promotion becomes acceptable and appropriate. The success of these programs is fascinating and ranges from educating communities of farmworkers to improving health care access to communities. At least ten states have an active lay health promoter program for farmworkers. Most are small programs, all are funded through short-term grants. If programs were given the means, we are convinced lay health promoters could positively curtail the spread of HIV infection and TB and have a resounding impact on the health of the nation.

Migrant clinicians are dedicated people who, like farmworkers, are accustomed to working with very little. Programs with the latitude to be innovative and to experiment with ideas like the lay health promoter concept have reported great success. But migrant clinicians are frustrated in their efforts to serve the working poor–frustrated by the lack of sufficient dollars to address the escalating need and frustrated by a federal health care system that rewards numbers and not successful innovations in care.

Migrant health centers function in isolation not only from one another but from the larger mainstream health care communities. They do not choose this isolation, but in reality they function as islands of care for an often misunderstood and undervalued population in communities where residents do not themselves have adequate access. The creation of migrant health centers was intended to ease the access and reduce the barriers encountered by farmworkers, as well as to lessen the overburdening of health delivery services in rural areas caused by the seasonal influx of workers. Unfortunately, many agencies and individuals assume that the health of farmworkers is the province of migrant health centers alone. This mentality has led to the inadvertent creation of "islands of care" in our health care system.

With only 104 migrant health centers for the entire nation, there are great geographic distances between these sources of care. With an annual appropriation of $57.9 million, these centers serve approximately 500,000 farmworkers at a cost of about $100 per person per year (a level of funding that is insufficient to cover the health needs of a well individual for a year, let alone an ill one) Migrant Health Program, 1989). This represents fewer than 20 percent of the national migrant and seasonal farmworker population.

We feel certain that the majority of farmworkers do not have access to primary care services for reasons identified previously.

The problems farmworkers face can ultimately be eased only by a fundamental change in the economic dynamic that is now in place. This change would include a decreased expectation by the American public for cheap food and the cheap labor needed to harvest it. Historically, migrant and seasonal farmworkers have worked in a system that virtually constitutes social and economic slavery. We must provide them with the level of care that all members of society deserve. To do so will require additional funding, coordination of services both in local situations and across the nation, and encouragement rather than bureaucratic barricades of creative solutions to problems.

Farmworkers must not be forgotten in the process of health care reform. Until the injustices of the current system are recognized and changed, it will be impossible for health care providers to significantly improve the health status of the most undervalued population in our society.

REFERENCES

Call, R. L., *et al.*
1987 "Dental Caries in Permanent Teeth in Children of Migrant Farmworkers," *American Journal of Public Health*, 77(8):1002–1003.

Castanares, T.
1990 "El Nino Sano," *Migrant Health Newsline*, 7(1):4. Austin, TX: National Migrant Resource Program, Inc.

Castro, K. and J. Narkunas
1989 "Seroprevalence of HIV Infection in Seasonal and Migrant Farmworkers: Preliminary Results," *Migrant Health Newsline*, 6(4):1. July/August. Austin, TX: National Migrant Resource Program, Inc.

CDC
1992 "Prevention and Control of Tuberculosis in Migrant Farmworkers," *MMWR*, 41(RR-10).

———
1988 "HIV Seroprevalence in Migrant and Seasonal Farmworkers–North Carolina, 1987," *MMWR*, 37:517–519.

———
1986 "Tuberculosis among Migrant Farmworkers–Virginia," *MMWR*, 35:467–469.

Cieseilski, S. D., *et al.*
1991 "The Epidemiology of Tuberculosis among North Carolina Migrant Farmworkers," Journal of the American Medical Association, 265:1715–1719.

Dever, A.
1991 "Migrant Health Status: Profile of a Population with Complex Health Problems," Migrant Clinician's Network Monograph Series. Austin, TX: National Migrant Resource Program, Inc.

Grube Robinson, J.
1990 "The Camp Health Aide Program," *Migrant Health Newsline*, 7(1):1. Austin, TX: National Migrant Resource Program, Inc.

Hendrickson, E.
1990 "Farmworker Exposure to Cholinesterase Inhibiting Pesticides in Northern Colorado," *Migrant Health Newsline*, 7(6):1. Austin, TX: National Migrant Resource Program, Inc.

Koday, M., *et al.*
1990 "Dental Decay Rates in Children of Migrant Workers in Yakima, WA," *Public Health Reports*, 105(5):530–534.

Laredo Morning Times
1992 "Babies Born Without Brains," Laredo, TX, January 21.

Larson, K., *et al.*
1992 "Maternal Care Coordination for Migrant Farmworker Women: Program Structure and Evaluation of Effects on Use of Prenatal Care and Birth Outcome," *The Journal of Rural Health*, 8(2):128–133.

Littlefield, C. and C. Stout
1988 "A Survey of Colorado's Migrant Farmworker Access to Health Care," *International Migration Review*, 21(3):688–708.

Lyons, M.
1992 "Study Yields HIV Prevalence for New Jersey Farmworkers," *Migrant Health Newsline*, 9(2):2. Austin, TX: National Migrant Resource Program, Inc.

Meister, J. and J. de Zapien
1990 "Un Comienzo Sano/Health Start," *Migrant Health Newsline*, 7(1):2. Austin, TX: National Migrant Resource Program, Inc.

Migrant Clinician's Network
1993 "National Health Care Reform: Basic Principles for the Farmworker Population." Position Paper. Austin, TX: National Migrant Resource Program, Inc.

———
1988 "CLEF, An Introduction." Austin, TX: National Migrant Resource Program, Inc.

Migrant Health Program
1989 "Migrant Health Program Three-Year Strategic Work Plan, 1989–1991."Washington, DC: Department of Health and Human Services.

Mines, R., *et al.*
1991 "Findings from the National Agricultural Workers Survey (NAWS) 1990. "Washington, DC: U.S. Department of Labor, Office of Program Economics.

National Migrant Resource Program
1987 "Be Aware! Common Cultural Practices and AIDS," *Migrant Health Newsline*, 4(7):1. Austin, TX: National Migrant Resource Program, Inc.

Pennsylvania Department of Health
1991 "TB/Syphilis/HIV Screening Project." Chambersburg, PA: Keystone Migrant Health Program, Sep. 8.

Puente, A. M.
1988 "CPCP Data for 1988," *Migrant Health Newsline*, 7(5):2. Austin, TX: National Migrant Resource Program, Inc.

Vasilion, T. M.
1992 "Knowledge of AIDS among Female Hispanic Migrant Farmworkers in Virginia," *Migrant Health Newsline*, 9(2):2. Austin, TX: National Migrant Resource Program, Inc.

Watkins, E. L., *et al.*
1990 "North Carolina Migrant Lay Health Advisors," *Migrant Health Newsline*, 7(1):3. Austin, TX: National Migrant Resource Program, Inc.

Wilk, V. A.
1986 "The Occupational Health of Migrant Farmworkers in the United States," 2nd Ed. Washington, DC: Farmworker Justice Fund, Inc.