OFFICE OF COMMUNICATIONS • 301-443-3376 • April 1998

Health Care Access for Farmworker Children

Overview	What Works to Get and Keep Children Involved in Migrant and Seasonal Farm Work in Health Care?	Model Programs Serving Migrant Children	References

Each year, roughly 1 million American children move from field to field, State to State, with their parents, harvesting the crops that nourish the Nation. Exposure to pesticides, infectious disease, and sub-standard living conditions makes these children susceptible to poor health. Most are eligible for Medicaid, but their constant movement from place to place prevents them from enrolling in the State-based public insurance program. Access to health care is minimal, at best.

In August 1997, the Clinton Administration proposal to insure the Nation's 10.6 million uninsured children and assure them access to care, became law. The Children's Health Insurance Program (CHIP), Title XXI of the Social Security Act, extends to States $24 billion over 5 years to expand Medicaid or create new children's health insurance programs.

CHIP also challenges States to eliminate some of the barriers that hinder all disadvantaged children's access to care. These and other efforts to improve access to the child health care system may also improve access to care for migrant and seasonal farmworker children.

- Most (66 percent) farmworkers who have children keep their children with them as they move from place to place.
- An estimated 250,000 children each year travel with their parents and/or themselves perform migrant and seasonal farm work. [8]
- Nearly three-fourths (72.8 percent) of children who are involved in migrant and seasonal farm work have no health insurance. They may be eligible for Medicaid, but their constant moving, often across State borders, makes enrollment exceedingly difficult. [9]
- Children involved in migrant and seasonal farm work have diseases not often associated with modern American living. A third of the migrant children in one study had intestinal parasites, severe asthma, chronic diarrhea, Vitamin A deficiency, chemical poisoning or continuous otitis media, which can lead to permanent hearing loss and language delay. [5]
- Primary caregivers assessed the health of Mexican American migrant children in their care to be poor or fair (rather than good or excellent) two to three times more often than Mexican-American children not involved in migrant or seasonal farm work (15.4 percent of migrant children vs. 5.9 percent of non-migrant children). [9]
- Newborn infants in migrant families had a significantly higher incidence of congenita

health problems as well as disorders and diseases of the ear, nose, and throat than the general U.S. population. 2

- Exposure to toxic pesticides and other chemicals used in agriculture is a particula problem for migrant children. One study found that 48 percent had worked in fields still wet with pesticides;36 percent had been sprayed with chemicals directly or indirectly; and 34 percent of the children's homes had been sprayed in the process of spraying nearby fields. 7

What Works to Get and Keep Children Involved in Migrant and Seasonal Farm Work in Health Care?

The Health Resources and Services Administration's Bureau of Primary Health Care Migrant Health Program provides primary health care services to 500,000 seasonal and migrant farmworkers and their families each year. Nearly half (45 percent) of those served by HRSA's migrant health centers are children. The program is able to serve only 15 percent of the 3 to 5 million individuals who work seasonally in America's fields. Seasonal and migrant farmworkers face multiple barriers to health care access, including cost (farmworkers earn, on average, less than $7,500 each year), language (about 80 percent are Spanish-speaking Latinos), and immigration concerns (although 63 percent are legally authorized to work in the U.S.). 2,11

Typically, Migrant Health Centers provide services within migrant camps, working with local partners. Some of the most effective train farmworkers to work with their peers, advising them on health problems, encouraging healthy behaviors, and encouraging them to seek care when needed. Migrant Health Centers are staffed with individuals familiar with the lay of the land and the customs and culture of migrant labor camps. They have created formal and informal links with each other, to provide continuity of care to people for whom relocation is a way of life.

To address the many problems that children involved in seasonal and migrant farm work experience, Migrant Health Centers have found they must make a number of accommodations.

Increasing Outreach Service Delivery Capacity has proven to be one of the most effective strategies for identifying and treating migrant children. Outreach is necessary for enrolling and keeping migrant children in ongoing preventive health care and also in bringing sick children into care.

Increasing Linguistic and Cultural Competency is a special challenge in serving children involved in seasonal and migrant farm work. Migrant Health Centers report that they are beginning to see families from rural Mexico and isolated areas of Central America who speak dialects unknown to Spanish-speaking staff. 6

Increasing Medical Records Transfer is difficult, but imperative in serving such a mobile population. Migrant children are susceptible to a medical feast or famine, and may be alternately over-treated and under-treated simply because their medical histories are unknown to current providers. According to the Migrant Clinicians Network, no other group of children in the U.S. has such simultaneously high incidence of both over-immunization and under-immunization.

Improving Traditional Public Health Services, such as providing potable water, assuring sanitation services in the fields, guarding against pesticide exposure, and addressing sub-standard housing conditions are important components in building comprehensive systems of primary care for migrant children.

Simplifying Enrollment and Quick Response benefit all disadvantaged children, but migrant children are especially likely to need services at the time they first seek them out.

The most common reasons seasonal and migrant farmworker families bring their children to a Migrant Health Center are as follows: [2]

Age Group	Main Health Issue Resulting in a Clinic Visit at a Community and Migrant Health Center (C\MHC) [2]
<1 year	**Newborn complications, well baby check-up, upper respiratory tract infection, otitis media, other infectious disease, and nutritional problems**
1-4 years	**Health maintenance, otitis media, other infectious disease, and nutritional problems**
5-9 years	**Health Maintenance, otitis media, dermatological, parasitic problems, other infectious disease, and dental diseases**
	Dental diseases, acute conjunctivitis, contact dermatitis, other infectious diseases, respiratory problems, and work related conditions
15-19 Girls:	**Pregnancy, dental problems, diabetes, health maintenance, other infectious disease**
Boys:	**Dental diseases, contact dermatitis, health maintenance, other infectious disease, respiratory disease, and work related conditions**

Model Programs Serving Migrant Children

Wisconsin operates a Medicaid reciprocity system. Migrant and seasonal farmworker families with valid medical assistance cards from any other state automatically qualify for Medicaid in Wisconsin. They need not re-establish eligibility to receive services. The State also uses average annual income, rather than monthly earnings, to qualify families for Medicaid. Farmworker earnings vary considerably from month to month and a single higher income month could make them ineligible for some Medicaid programs.

The Camp Health Aide Program in Monroe, Michigan recruits interested migran farmworkers and trains them to become health aides--lay workers who educate and assist their neighbors and co-workers in nutrition, first aid, prenatal care, well-child care, environmental protections, diabtes, hypertension, sexually transmitted diseases, HIV/AIDS, and mental health. Camp Health Aides also act as liaisons with public and private health services. Migrant and seasonal farmworkers in the eastern, midwestern and western regions, where the program supports more than 500 aides, have gained better access to health care, their illnesses are diagnosed and treated sooner, and the systems that serve them have become more cost-effective.

References

1. Congressional Research Service Report for Congress. *Children's Health: Insurance Coverage, Community Clinics, and Access to Care* . Social Legislation, Education and Public Welfare Division. August 1997.

2. Dever, GEA. *Migrant Health Status: Profile of a population with complex health problems.* Migrant Clinicians Network, Monograph Series. National Migrant Resource Program. Austin, TX. 1991.

3. Mull, LD. *Implementation of the Helsinki Accords: Migrant Farmworkers in the United States.* Briefings of the Commission on Security and Cooperation in Europe. Washington DC. May 1993. Page 97.

4. National Advisory Council on Migrant Health. *1993 Recommendations of the National Advisory Council on Migrant Health*. U.S. Department of Health and Human Services, Bureau of Primary Health Care. Rockville, MD. May 1993.

5. Otarola, AJ. *The earlier the better: Serving infants and toddlers in Migrant Head Start.* Region XII. Migrant Head Start Resource Access Project. 1996.

6. Pindus, NM. O'Reilly, FE. et al. *Services for migrant children in the health, social services, and education system.* The Urban Institute. Washington, DC. May 1993.

7. Pollack, SH. *The Health Hazards of Agricultural Child Labor.* Migrant Health Clinical Supplement. National Migrant Resource Program, Inc. Austin TX. May/June 1990.

8. Unpublished Report by the U.S. Department of Labor. Mines, R. *The Health of Immigrant Children Farmworkers.* Washington DC. April 1997.

9. Ruducha, J. *Migrant Child Health: The role of social, cultural, and economic factors.* National Migrant Resources Program, Inc. Austin, TX. 1994.

10 . *Wisconsin hopes to improve farmworkers health.* State Legislatures: National Conference of State Legislatures. May 1997.

11. Mortality and Morbidity Weekly Report, Pregnancy-related behaviors Amoung Migrant Farmworkers. Vol. 46/ No. 13. P. 283.

12. Public Law 105-33. H6108- H6114; Congressional Record; Subtitle J Chapter 1- State Children's Health Insurance Program. July 29, 1997.

For more information, contact: Office of Communications, HRSA
5600 Fishers Lane, Room 14-45
Rockville, MD 20857
Telephone: 301.443.3376
Fax: 301.443.1989
Web Site: http://www.hrsa.gov

Go to: Fact Sheets | HRSA News Room | HRSA | HHS