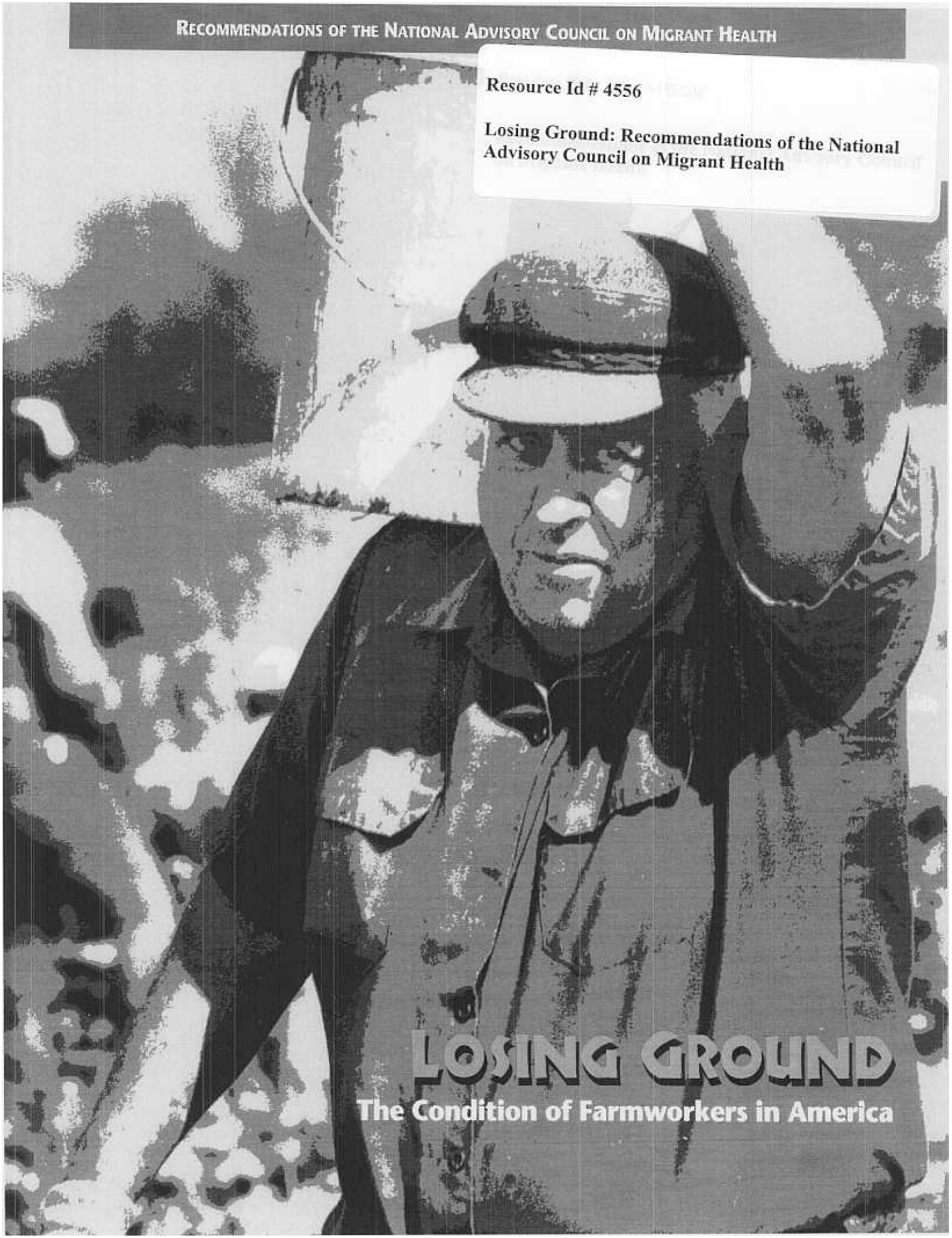

LOSING GROUND

The Condition of Farmworkers in America

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Recommendations
of the
National
Advisory Council
on Migrant Health

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SUMMARY OF RECOMMENDATIONS

The recommendations of the National Advisory Council on Migrant Health are based on previous recommendations, testimony given to the Council, and the Council's continuing analysis of the conditions under which migrant and seasonal farmworkers must live and work. Though the urgency for resolution of individual recommendations may vary, the Council acknowledges that these problems will continue to be central issues of concern for farmworkers into the next century.

The difficulties encountered by farmworkers are unique to their occupation. These include mobility, multiple employers, impoverished and physically challenging working and living conditions, uncertain access to health care, and the problems created by having few, if any, community ties. These conditions come together to create a kind of disenfranchised citizen—an orphan group within our country for whom no one wants to take responsibility.

All of the recommendations reflect the following currently unresolved issues concerning farmworkers:

Inadequate representation within the government at the national, state, and local levels.

- Lack of research in all areas which would provide census, mortality, general demographic, and other information about the farmworker population.
- Insufficient enforcement of laws and regulations regarding safety, wages, sanitation, employee rights, etc.
- Inadequate recognition in national and state legislation, and exclusion from most social, health care, and education programs. Legislation frequently omits provisions needed to include farmworkers and their families.

These areas of deficiency are the core problems that all the recommendations attempt to address in greater detail, providing concrete, workable, and necessary solutions.

HEALTH ACCESS

Farmworker access to health care has become the primary challenge. As managed health care and fiscal conservation become the focal point of health care in the United States, farmworkers continue to be pushed further down on the list of priorities. Though the efficacy of managed care is evident, this approach does not address the unique circumstances under which farmworkers function or their limited participation in insurance and Medicaid plans. Prior to the advent of the managed care movement, less than 20 percent of the total farmworker population was reached annually through Public Health Service (PHS) funds. That number will not improve appreciably under managed care. Critical health problems, including those related to oral

health, will continue for the majority of the population unless policies are developed to specifically address them.

The Council therefore recommends that the Secretary continue to advocate for inclusion of farmworker populations in the following areas of health care and health care reform:

National and state health care reform legislation must include provisions that address the access barriers created as a result of farmworkers' mobility. Benefits must be portable, coverage needs to extend beyond the immediate service areas and across state lines to provide ongoing protection, and the definition of "employer" must be redefined more flexibly in order to provide better access to health care by farmworkers and their families.

Specific language must be included to meet the needs of farmworkers and their families in all Medicaid disbursement regulations developed as a result of state-based health care reform.

Outreach and translation services are an essential component in farmworker health care and are continually at risk of being seriously reduced or eliminated. Outreach services should be reimbursable through Medicaid and should also be made an allowable cost through the Federally Qualified Health Center (FQHC) program.

- All migrant health centers should be funded to provide oral health care.

  The Medicaid Reciprocity Feasibility Study needs to move to the next phase of implementation. Appropriate funding should be provided to continue this intrastate study or another successful design.

- Manpower is essential to the implementation of the above recommendations. There continues to be a serious lack of access to mental health professionals, doctors, dentists, social workers, nutritionists, and health educators who share and understand a common language and cultural background with farmworkers.

  - There must be a focus on training and placing dentists, optometrists, and primary care providers who deal with occupational health and safety issues.

  - Loan repayment programs need to be expanded to include a full range of health care professionals.

    Training programs for health professionals should offer incentives for working with farmworkers.

    Efforts to recruit Hispanic and other migrant youths during their school years should be continued. The Department of Education should offer training for migrant youths in clinical and allied health professions, and should make residency programs mutually beneficial to health centers and residents.

MENTAL HEALTH

The conditions under which farmworkers must live and work create tremendous stress and difficulties in maintaining a stable family life, yet farmworkers continue to have less access to community-based mental health facilities, child care facilities, and other social services because of their mobility.

The Council recommends that the Secretary take the following department-wide steps to provide better mental health and family services:

- Include specific language within the mental health and substance abuse statutes requiring states to include farmworkers and their families.

  Collaborate with the Substance Abuse and Mental Health Services Administration (SAMHSA) and other national, state, and local agencies to conduct research in each state to ascertain how farmworkers' needs are met within each jurisdiction. Such research would allow SAMHSA to better assess what areas are being overlooked and by which states.

  Expand mental health to fund services to farmworkers, and develop specific initiatives to increase the level of culturally competent mental health professionals.

- Include migrant and community health center representatives on state planning committees, thus enabling them to help establish policy and service priorities and to influence funding decisions in individual states. The services provided to families under Title XX, Consolidated Child Care Development Block Grant, At-Risk Child Care Block Grant, Head Start, Minority Health Programs for Women, and numerous other programs also need to be made available to farmworkers and their families.

  Farmworker mental health care should also be a reimbursable service through Medicaid and an allowable cost through the FQHC program.

  Farmworker mental health should be included in all disbursement regulations developed at the state level.

OCCUPATIONAL SAFETY AND HEALTH

Farmworkers continue to have the highest work-related injury and mortality rate in the nation. The Council recommends that the Secretary, working with the White House Domestic Policy Council, continue efforts to address this issue in the following manner:

We strongly recommend a national workers compensation program for all farmworkers. To that end, a national study should be conducted to document the impact of workers compensation on employers and workers.

We also recommend a joint effort on the part of federal and state agencies which regulate enforcement to ensure more diligent enforcement of the laws and regulations that protect farmworkers and their families.

Encourage the Migrant Health Program's continued participation in the development of the National Agricultural Workers Survey (NAWS), using the migrant health center network to provide accurate data on the number of work-related injuries and the extent of the disability.

APPROPRIATIONS AND AUTHORIZATIONS

Current migrant health appropriations reflect an annual total expenditure of approximately $130 per individual patient user per year. At this rate, only 12 percent of the total farmworker population is being served. The Council recommends that the Secretary support, at a minimum, the current funding level of $65 million for provision of care to farmworkers. In the long run, the Council supports an overall increase in appropriations to the program.

We further recommend, in regard to potential consolidation reauthorization, that farmworker-specific language be carefully worded to assure proportionality of funding among all consolidated programs. Loss of proportionality in a consolidated authorization could result in a significant loss of access to those farmworkers we are currently able to serve.

HOUSING

Though some progress has been made, housing for farmworkers remains a serious problem. The Council recommends that the Secretary take the following actions:

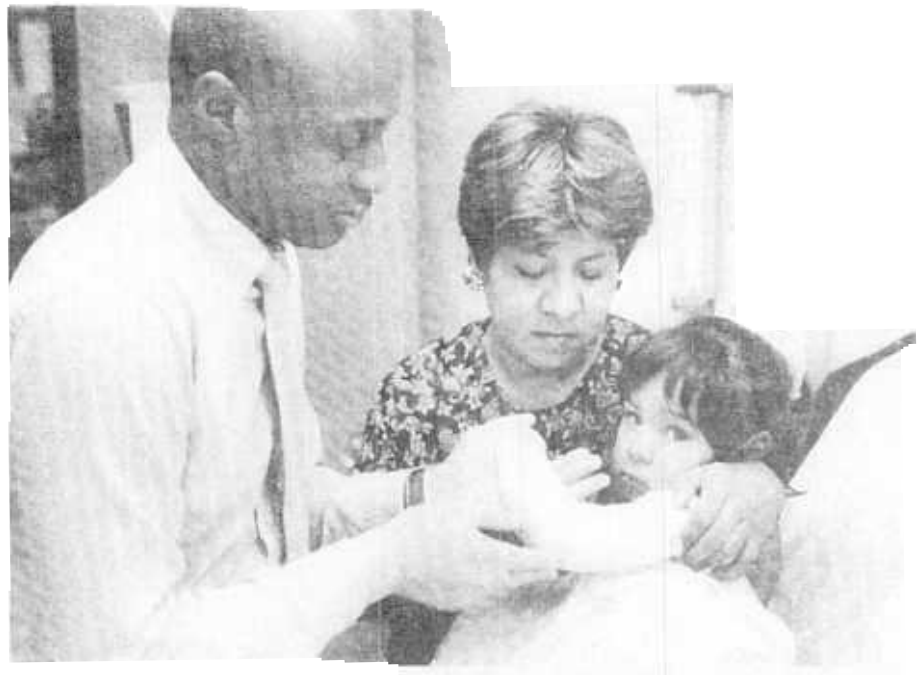
Request the Secretaries of the Departments of Transportation, Housing and Urban Development, and Agriculture to develop joint initiatives and commit funds to developing housing for farmworkers.

- Also, request that the Secretaries implement a strategy to encourage community based organizations, migrant health centers, and employers, as well as state and county governments, to work together to develop housing on location for farmworkers.

RESEARCH

Research is needed in all areas having to do with farmworkers in order to provide data needed for even the most rudimentary projections, census, health indicators, etc. The Council recommends that the Secretary:

- Direct agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the Centers for Disease Control and Prevention to initiate this much-needed research.
- Provide increased funding specifically for research, or dedicate a minimum percentage of all research money for farmworker issues.
- Submit applications for a portion of the 1 percent funding available to the Bureau of Primary Health Care for evaluations.



HEALTH ACCESS

Background: HEALTH ACCESS

"In the last thirty years, a variety of newspaper exposés, television documentaries, government studies, and Congressional hearings have focused on the plight of farmworkers in the United States. Much of what Edward R. Murrow revealed about migrant farmworkers in the 1959 broadcast, 'Harvest of Shame,' is still relevant today. The problems of poverty, isolation, exploitation by crew leaders, and unhealthy living and working conditions have not disappeared."[22]

Farmworkers are responsible for harvesting over half the produce in some parts of the U.S.[26] Every state in the union uses the labor of seasonal and migrant farmworkers. Their grueling, underpaid work helps to provide a vast array of fresh, affordable fruits and vegetables which they themselves cannot afford. The following is a profile of the farmworker population in the United States:

- It is estimated there are three to five million farmworkers in the U.S.[5]

  Thirty-eight percent of this population consists of women and children under the age of fourteen.[8]

  The farmworker population is comprised of people from a mixture of ethnicities, with the majority being Hispanic.

  The average annual migrant farmworker family income is substantially lower than the national poverty threshold. Most farmworkers work for minimum wage.

- Almost half of the nation's migrant farmworkers have less than a ninth-grade education.

- The infant mortality rate for farmworkers is 25 percent higher than the national average.[6,7]

  Migrant farmworkers frequently lack transportation and cannot get from the job site to a clinic.

  Their physical and linguistic isolation may leave farmworkers unaware that the services they need are even available.[2]

  Migrant farmworkers are subject to more occupational injuries and mental health and substance abuse problems than the general population.

- Access to oral health care is severely limited, with waiting periods of up to six months for an appointment. Many studies cite oral disease as the most frequent health problem within this population.

  As a population, farmworkers suffer a higher incidence of malnutrition than any other sub-population in the country.

They also experience high rates of diabetes, hypertension, tuberculosis, anemia, and parasitic infections,[6] while their low income levels make private health care prohibitive.

The Secretary must assure that the unique issues facing farmworkers are addressed in the development of national health care reform. Reform must recognize the mobility of these workers and the need for portable benefits as they move from state to state.

MEDICAID

Farmworkers precisely fit the profile of the population the Medicaid program was designed to protect, and it was anticipated that Medicaid would increase access to basic health care for farmworkers. However, this has not been the case. As a group, farmworkers have more difficulty accessing the benefits of the Medicaid program than any other population in the nation.[1] Since the focus of health reform has taken a turn toward giving more control to individual states, specific language must be included in federal legislation to insure that farmworkers can participate in any state-based model designed to provide medical coverage to the poor. The current lack of health access for farmworkers under Medicaid cannot be allowed to continue in any reformed system.

By way of background, the current Medicaid system was designed to provide a "safety net" for the lowest-income members of society. It was meant to insure that impoverished citizens, especially pregnant women and children, had access to adequate health care. The Medicaid program is federally mandated, but is administered by individual states with both federal and state contributions. The federal government has provided broad guidelines for the program, but these guidelines are open to interpretation by the states, and the administration of the Medicaid program is not uniform between states.[3]

Regretfully, participation of eligible farmworkers is impeded by the state-based structure of the system, by eligibility requirements which are not uniform, and by benefits which are not portable. It is unconscionable that farmworkers cannot qualify for Medicaid because of the conditions imposed by their employment.

Migrant farmworkers make their living by working the peak seasons of agriculture. This entails moving frequently to obtain hard labor at low wages, living in substandard housing, and being exposed to numerous health hazards.[4] Many farm laboring families travel as a unit, with as many family members working as possible. It is not uncommon for a farm laborer to spend less than a month in one locale.[1] This fact alone accounts for one of the major barriers farmworkers face when they attempt to access the Medicaid system.

The law allows farmworkers to apply for Medicaid in whichever state they are working.[1] However, states are allowed forty-five days to process an applicant's eligibility forms. By the time this process is completed, many farmworkers have had to move on to the next job, frequently in another state.[2] Once a worker's eligibility for the program is established, it must still be re-validated

every one to six months, depending on the state and the eligibility category.[1] If the worker cannot be located when it is time to re-certify eligibility for benefits, the benefits lapse.[2]

The law allows states to reciprocate on Medicaid benefit eligibility, but the administration of the system is not uniform among states. When one state honors another state's Medicaid eligibility for a recipient, the paperwork tangle involved in billing for services may cost more than the value of the services rendered. If the patient must be contacted in order to complete paperwork and that patient is a migrant farm laborer, it may not be possible to locate him or her. These circumstances do not encourage states to accommodate the need of migrant farmworkers to be enrolled in the Medicaid system.[1]

Private providers are sometimes reluctant to accept Medicaid patients. Farmworker Jorge Miranda described his experiences:

> *I got a [Medicaid] card from the state for my children. The medical card is not accepted [by many providers]. Sometimes they don't want to attend us even if I pay cash ... And I asked, 'Why don't you attend me,' ... and they told me that they couldn't take care of me because I had the card.*[9]

In the meantime, farmworkers continue to suffer from a host of preventable and treatable diseases which Medicaid would cover, but for which they cannot obtain treatment.[2] Preventive care is more cost effective than catastrophic care, but under the current system most farmworkers do not have that option. A nationally administered program to provide health care to farmworkers could preclude the problems occurring in the individually administered state programs.

A feasibility study was conducted to create a demonstration project for improving the continuity of Medicaid coverage for farmworker. This study, contracted by the Health Care Financing Administration (HCFA) in cooperation with the Migrant Health Branch, Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, proposes a demonstration that facilitates interstate reciprocity of Medicaid benefits through the use of an interstate enrollment transfer model.[27]

The interstate transfer model allows participating states to recognize each others' eligibility determinations, thus streamlining the enrollment process. Medicaid-eligible farmworkers and their dependents would complete a standard application in a participating state and receive a Medicaid card. When they moved to another participating state, they would present this card along with proof of agricultural employment at selected entry points. At such locations, migrant farmworkers would need only to fill out a simple one-page form to be entered into the enrollment files. For administrative simplicity, the eligibility workers trained to transfer enrollment would be limited to sites and counties known to have migrant farmworker labor.

A pilot study between two or more states would be a low-cost way of determining how many people would actually use health care services in states other than their home base. The model would not lower the eligibility standards for farmworkers; it would only make the benefits more accessible. It would apply the proven theory that primary care is less costly than emergency care. And farmworkers are just one of many mobile populations. If successful, this model could be used for other mobile populations, such as workers in the building and trucking industries.

ORAL HEALTH

Access to dental services is an area of health care which has reached crisis proportions for farmworkers and their families. A recent survey of migrant health clinics, conducted to determine what types of services are available, found that of 73 respondents, 18 offered no dental services at all.[28] Of the clinics that had one or more dentists, the waiting period for an appointment ranged from two weeks to two months. Most farmworkers have moved on to the next job by the time an appointment can be obtained.

The medical director of a clinic in Oregon said it best

> *There is a dire need for expanded access to dental care for agricultural... workers. Adults, elderly, children... suffer from severe dental crisis, periodontal disease, and general poor oral health such that these conditions adversely affect their general health. Current waiting periods for clients at our own dental clinic extend to six months or longer. Dental needs are at a critical level.*[29]

OUTREACH

One of the more successful efforts to reach farmworkers has been the approximately 130 federally subsidized migrant health centers, located in cluster areas where large numbers of migrant farmworkers congregate during the peak harvesting season. Unfortunately, these clinics are able to accommodate less than fifteen percent of the target population.[10] Even when affordable health care facilities are available, farmworkers experience greater difficulties accessing them than the mainstream population. There are many reasons for this problem, including lack of transportation and the inability of many farmworkers to afford the loss of a day's pay.[12]

In response to farmworkers' difficulty accessing the health care system, outreach programs attempt to take services to migrant farmworkers. The federal Migrant Health Program defines outreach as "making services known to the population and insuring that they can access all the services which are available." Outreach programs, according to the Migrant Health Program, should improve utilization and effectiveness of health services, provide comprehensive health services, and be accessible, acceptable, and appropriate to the population being served.[11] These guidelines recognize the demographic and cultural diversity within the farmworker population and the flexibility required to connect workers with services. Outreach approaches range from

taking services to the target population to training the population to serve itself. Outreach programs are an effective means of consolidating the fragmented social services that frequently frustrate farmworkers' attempts to obtain aid.

Outreach programs use varying means to successfully reach migrant populations that were previously isolated from health and social services. Although there are numerous outreach programs in place at both the local and state levels, the following two programs have been thoroughly documented and will serve for discussion purposes: The Maternal and Child Health Migrant Project run by the Department of Maternal and Child Health, School of Public Health, University of North Carolina at Chapel Hill in conjunction with Tri-County Community Health Center (TCCHC) in Newton Grove, and the program administered by the Midwest Migrant Health Information Office (MMHIO) in Michigan.

The Maternal and Child Health Migrant Project, administered in North Carolina through TCCHC, focuses on assessment of the health and nutritional status of pregnant women and children, and on means of improving their condition. Clinic staff have found the major barriers to accessing health care among farmworkers to be lack of transportation, inability to speak English, and lack of access to child care. The key component of the project's plan to reduce these barriers is the use of farmworker women as lay health advisors. Clinic staff train these women to provide group and individual health education sessions, first aid, follow-up, translation, prescription instruction, referrals and appointments, liaison with outreach nurses, and distribution of literature. The clinic uses a bus to transport farmworkers to appointments, and also enlists volunteers to help with transportation. The project coordinates the services of the local county health department, social service agencies, hospitals, Migrant Head Start center, and WIC, connecting migrant farmworkers with the necessary social services. The center's maternal health nurse arranges for bilingual clinic staff to assist with deliveries in local hospitals in exchange for systematic referral of TCCHC patients for postpartum care.

The Camp Health Aide program at the Midwest Migrant Health Information Office was developed by the federal government in conjunction with the Catholic Consortium for Migrant Health Funding to establish a model program which individual states would then be encouraged to take over. The State of Michigan has since assumed full responsibility for the program within its borders. Camp health aides are recruited much the same way as the lay health advisors in the North Carolina program, with similar goals and outcomes. The presence of the camp health aides helps to overcome the language barriers, prejudice, and long work hours that prevent many migrant farmworkers from obtaining the medical attention they need.[13] Camp health aides are members of the farmworker community, and their example reinforces the idea that preventive health care has value.[14] MMHIO is now working to extend its outreach work to the downstream home bases of migrant farmworkers.[15] The Migrant Health Program has issued *Community Outreach Guidance: A*

Strategy for Reaching Migrant and Seasonal Farmworkers, which details the diversity of outreach programs and considerations in implementing them.[16]

HEALTH CARE PROVIDERS

There remains one more impediment to health care access for farmworkers: Successful programs require dedicated, competent staff from a broad range of health professions who share or understand the language and cultural background of farmworkers. Health professionals serving the migrant farmworker population have greater demands placed upon them than practitioners in traditional medical settings.[17] These individuals must be willing to coordinate their efforts and go beyond the boundaries of traditional health care services in order to care for their clients.

Migrant health clinics were dealt a blow in the recruitment of physicians by the downsizing of the National Health Service Corps (NHSC). In 1987, 50 percent of the physicians in migrant health centers were serving out NHSC terms of two, three, or four years. With the expiration of those terms, NHSC physicians had no obligation to remain at the clinic. However, many do remain, and they become much-needed advocates of primary care services for underserved communities and populations.

> *I was dying to take on a four-year NHSC scholarship obligation when I was in medical school. For various reasons I got only a two-year scholarship. After my internship, I went immediately to work in a migrant and community health center in the San Joaquín Valley as a NHSC doc, a USPHS commissioned officer, and a rural general practitioner. Thus was launched a career, so far spanning 16 years of community-oriented primary care in clinics serving the poor in three states.*
>
> *I currently work at a rural migrant and community health center, serve as a national ombudswoman to the BPHC on migrant health, and volunteer on summer evenings with door-to-door medical care in farm labor camps in my neighborhood. My NHSC scholarship allowed me to complete my medical education, and my payback. Two years changed my life—I hope I continue that payback for my remaining years as a physician. (Tina Castañares, MD, testimony before the National Advisory Council for the National Health Service Corps, 1995)*

The average length of employment of medical staff at migrant health centers is between three and four years.[18,22] Migrant health centers face another disadvantage because the Public Health Service Act's section 329/330 provision prohibits them from using grant money for student loan assumption, which is a good recruitment incentive.[18] The typical migrant health center cannot pay wages that are competitive with other health care facilities.[22] To be effective, migrant

health clinics make unusual demands of their staffs, but they are financially crippled in their ability to recruit and retain staff.

One affordable and effective means of staff recruitment is participation in preceptorship programs, which place medical and other health professional students in clinics where they practice under supervision. These programs promote migrant health centers as an attractive career option to participants after completion of their medical training. They provide existing health center staff with important academic linkages, and offer practice sites to medical schools and internship programs. Participation in these programs has resulted in better staff retention in migrant health clinics, and enthusiasm on the part of students for primary care and for community health practice.[18,5,23]

However, most of the existing programs are for physicians in training.[8] Collaborative training efforts and internships should be expanded to include the whole range of health care providers, including dentists, optometrists, mental health professionals, nurse practitioners, nurse midwives, and physician assistants.

Since the clinics cannot compete with mainstream salaries, they need to be able to offer other recruitment incentives to all types of providers, not just physicians. One way to do this would be to allow migrant health clinics to assume student loans for all staff members. The success of programs like the lay health advisor program also demonstrates that the farmworker community itself is a good source of capable bilingual, bicultural, motivated personnel for training and subsequent employment in the field of migrant health. Involvement of migrant students early in their education, before the dropout rate reduces their numbers drastically, could be an effective method to tap this resource, especially if loans, grants, and/or other incentives could be developed for farmworker students who pursue careers in the health professions.

Health care facilities with bilingual, bicultural staffs have implemented successful inter-disciplinary programs to cover the wide range of health and health-related social service needs of farmworkers.[17] However, there are still too few federally-funded migrant health center grantees nationwide. These facilities, with insufficient qualified practitioners to staff them, are meant to effectively serve a target population estimated to number up to five million.[18,19]

Domatila Tavara testified before the National Advisory Council on Migrant Health that, "What is needed [is] more doctors, more people who can provide ... assistance to those people. Those who have diabetes and tuberculosis, cancer, and different kinds of sicknesses ... the young women that are alone here and are pregnant expecting their first baby, they need a lot of help from all the clinics."[24] Another woman testified that it was not uncommon to wait for hours, even with an appointment, and finally be told that the doctor would not be able to see everyone that day.[25]

CONCLUSION

The barriers that prevent farmworkers from accessing health care must be addressed under any health reform system. The health care reforms currently being considered cannot be applied to mobile populations like migrant farmworkers. To be useful to mobile populations, Medicaid must be transferable from one state to another. The goal of the Council is to have universal coverage provided to all farmworkers and their families. Implicit in that goal is the need to maintain and expand the infrastructure of migrant and community health centers, which have demonstrated expertise in providing accessible, culturally competent health care to the farmworker population. Universal coverage to intended to include farmworkers will require provision of supplemental benefits, such as transportation, translation services, case management, and other services necessary for culturally diverse, under-served populations like migrant and seasonal farmworkers. Creative and flexible systems must be implemented to meet the needs of farmworkers and the providers who serve them.

Migrant and seasonal farmworkers have suffered from neglect by the American health care system. The failures of the past must not be repeated. The needs of farmworkers must be recognized in the health reform debate and addressed in new models of health care delivery.

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MENTAL HEALTH

Background: MENTAL HEALTH

"The migrant worker who comes [to Colorado] from Texas is... not allowed to speak up in matters which would require a change in legislation... . The people whose lives are affected... are not involved in the decision making." (Father Thomas More, Colorado Migrant Rural Coalition)[2]

PROFILE

Migratory farm work is by its very nature stressful and poses numerous health risks.[25]

- Because of the constant mobility necessitated by their employment, farmworkers do not have a good support system.

  They are also isolated from the communities where they temporarily live and work. This isolation leads to feelings of despair, depression and a lack of self-worth.[25]

- Farmworkers have an average education level of ninth grade.[25]

- Because migrant children usually travel with working parents as a family unit, the children's education suffers, as does their health and self-worth.[25,26]

The harsh realities of life in the migrant stream include poverty, hard manual labor, unsanitary living conditions,[14] lack of medical insurance or access to health care facilities,[15] high rates of illness, early death, economic uncertainty, and personal humiliation.[16,17] Farmworkers are poor, under-educated, and frequently face prejudice and hostility in the communities where they stop to work.[14] If they travel and work together, these same issues may affect entire farmworker families as well. Conversely, two in five of these workers live away from their families while doing farm work.[5] For single male workers who must leave their families behind in order to find work, social isolation and lack of recreational outlets takes its toll.

The mobile nature of the farmworker family often precludes access to mainstream health care services. Their need for mental health services goes almost unaddressed, even though the brutal conditions under which they live have been correlated with an increased incidence of mental health problems.[1,3]

CHILDREN

The national infant mortality rate for farmworker families is 14 out of 1,000, while a 1989 study found the infant mortality rate among California migrant farmworkers to be 30 out of 1,000 and the mortality rate for migrant farmworker children up to the age of five to be 46 out of 1,000.[23]

The stress of trying to maintain a stable family life under the circumstances described is devastating. Physician and child psychiatrist Robert Coles, in his series *Children of Crisis*, characterizes the psychological pressures of growing

up in the cycle of migrant farm work: "How literally extraordinary, and in fact how extraordinarily cruel, their lives are: the constant mobility, the leave-takings and the fearful arrivals, the demanding work they often manage to do, the extreme hardship that goes with a meager (at best) income, the need always to gird oneself for the next slur, the next sharp rebuke, the next reminder that one is different and distinctly unwanted, except, naturally, for the work that has to be done in the fields." Dr. Coles continues,

> *There is ... the misery; and it cannot be denied its importance, because not only bodies but minds suffer out of hunger and untreated illness... Migrant parents and even migrant children do indeed become what some of their harshest and least forgiving critics call them: listless, apathetic, hard to understand, disorderly, subject to outbursts of self-injury and destructive violence toward others. It is no small thing ... when children grow up adrift on the land, when they learn as a birthright the disorder and early sorrow that goes with peonage, with an unsettled, vagabond life.*[4]

Farmworker children also have difficulty staying in school. Flora Martinez testified before the National Advisory Council on Migrant Health, "Young field workers are dropping out of school again because they have to help their parents, they have to be able to sustain their family ... ."[11]

WOMEN

Women labor all day in the fields and bear the full responsibility for domestic labor when the official work day is over.[20] Women in the migrant farmworker population often receive little or no prenatal care during their pregnancies. Many pregnant farmworker women fall into high risk groups due to being younger than 18 or older than 35. Lack of money, lack of transportation, and lack of child care are all cited as reasons for not seeking prenatal care, as well as not perceiving a need for it.[18,12] Most pregnancies are unplanned, and many women do not use any form of birth control, although many of the women interviewed expressed a wish that they had not become pregnant. The results of living under such conditions are poor physical health, strained personal and family relationships,[16] increased incidence of child abuse, and an even greater incidence of unintentional child neglect.[14,21,22]

The social implications of the conditions under which migrant farmworkers live are as dire as the physical ones. One woman who fled from domestic violence with her baby described the situation she ran from. She and her husband and infant had shared one-room quarters with five single men. Over time her husband became increasingly violent and unpredictable. He began to beat her and the baby, and she was unable to predict what would initiate a violent episode. She fled after one of the men living with them also began battering her. She attributed her husband's behavior to a reaction to being "pushed around so

much," and speculated that "being treated like a slave is harder for men to accept."[4]

FAMILIES

The pressures of the farm work situation are expressed both tangibly, through chronic health problems, and intangibly, through emotional turmoil. Anxiety often takes the form of somatic symptoms such as headaches and neck pain.[1] Drug and alcohol abuse occur in high numbers.[5] Stress creates family situations that are often unstable, and sometimes abusive. Conflict erupts when children identify with the mainstream lifestyle and their parents enforce traditional values, fearing that their families will disintegrate.[1] The traditional solution to problems is for individuals to adapt to problems rather than attempt to change the circumstances that cause the problems. And so the problems are perpetuated.[1]

MENTAL HEALTH SERVICES

Delivering mental health services and family counseling and support to the farmworker community is not a simple matter. Farmworkers are often unaware that services exist, so they do not seek them out. The fact that farmworkers move so frequently makes it difficult for them to acquire care for chronic problems, and the physical barriers to delivery of services are formidable.

In addition, there is a critical lack of funding for farmworker-specific mental health services. One author states, "Mental health care for migrants has never been given consideration or time by the migrant [health] clinics or any other medical system in the United States."[7] Public mental health services in this country are funded primarily at the state level, with funds "flowing down" to provide services in local areas. While this method is adequate to serve stable populations, it does not meet the needs of a farmworker community which must be constantly moving by the very nature of its work. Funds are needed at the national level to develop outreach capabilities which will allow mental health services to be taken to the farmworker rather than vice versa.[7]

A work group funded by the Office of Substance Abuse Prevention recently recommended increasing appropriations for farmworker-specific mental health services at all levels, in addition to developing state and local strategies such as block grants to address farmworker substance abuse prevention. The group also stressed the use of lay health workers and the integration of mental health and substance abuse services with migrant health clinics as mechanisms to improve access.[8] It is critical that the use of lay workers, which is effective with both families and single male workers, be accepted as an appropriate intervention strategy.

For mental health intervention to be effective it must be culturally and linguistically acceptable as well as physically accessible. The intricacies of language and cultural barriers are numerous. The mental health of an individual is composed of complexities of belief, thought, and emotion. Such concepts are often expressed in language by idioms, terms that are understood

culturally but which literally may make no sense. Thus, when an Anglo practitioner listens to a young Hispanic woman telling him that she hears voices telling her to enter a convent, he may make a pathological diagnosis of auditory hallucinations with religious content when actually the woman is employing a figure of speech as harmless as saying she has a calling to the religious life.[1] If a practitioner lacks either the cultural or linguistic capability to detect such nuances, how is he or she to make an accurate diagnosis?[3] An example of the extremes such insensitivity can lead to is the 1966 finding that 30,000 Spanish-speaking Hispanic children in California had been placed in classes for the mentally retarded after being tested for mental capacity in English.[5]

To truly understand what a patient is saying, the practitioner must understand the client's cultural background as well as language. For this reason, the migrant farmworker community is best served by practitioners who are bicultural as well as bilingual.[1,3] As one rehabilitation coordinator commented, "[Mental health support groups] is a service that's provided to the Anglo community through mental health or private psychiatrists, but it is not provided for the farmworker. It's not even provided for the Hispanic population overall."[9]

Hispanic culture views illness differently from Anglo culture. While the mainstream culture regards illness as an impersonal and blameless event—the result of germs or fate—the traditional Hispanic culture regards illness and health as being connected to harmony between the natural and the supernatural. Thus, an individual's illness reflects on his or her relationship with the community and with God, and a system of folk medicine has developed to restore harmony to the body and the spirit when these relationships somehow become unbalanced. If the practitioner is not well versed in Hispanic culture and is ethnocentric and judgmental, the patient is likely to be alienated and uncommunicative. But even if the practitioner is sympathetic, it is not going to help to communicate on delicate and complex issues if he or she literally does not speak the same language as the client.

Bilingual/bicultural programs have been implemented successfully through medical clinics. The Camp Health Aide program in Michigan, which was implemented primarily as a medical outreach program to migrant labor camps, found that farmworker volunteer camp health aides experienced an increased sense of self esteem and empowerment.[10] La Clínica del Cariño in Hood River, Oregon, experienced such success with a lay health advisor/*promotora* program which recruited farmworker women as health aides that it developed a mental health program called La Familia Sana. The La Familia Sana outreach program conducts culturally competent mental health and substance abuse education for farmworker women and adolescents.[13] Family Health/La Clínica in Washington State established "*Las Comadres*," a gathering place for farmworker women who were depressed and cut off by migration from the feminine support network they had at home. The resulting access to peer support yielded favorable results.[1]

It has also been suggested that establishing mental health resources for migrant farmworkers in proximity to primary care clinics could help alleviate the stigma associated with seeking mental health services as well as reducing transportation barriers.[1]

CONCLUSION

The farmworker population is subject to pressures which greatly increase their risk of suffering from some form of mental illness. Their mobility further complicates the task of providing them with mental health care. The variation in their linguistic and cultural backgrounds require programs delivering services to them to also be bilingual and bicultural, or risk being ineffective. Relevant mental health services are simply not available in sufficient quantity to even begin to meet the need.

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OCCUPATIONAL SAFETY AND HEALTH

Background: OCCUPATIONAL SAFETY AND HEALTH

"You go to the fields and you think that it's a foggy day because it's so pretty and it's white, but it's actually the chemicals that have been sprayed." (Adelaide Romero, California)[14]

PROFILE

Agriculture is classified as the second most dangerous occupation in the United States.[3] The occupational and environmental health risks to farmworkers are discussed together here, as they are so closely intertwined in agricultural work. The following are some of the occupational and environmental hazards farmworkers must endure:

- Exposure to the elements: sun, rain, dust and pollen, and freezing temperatures.
- Exposure to a wide range of chemicals used in all stages of agricultural production.[3]
- Illness and disease caused by impure water sources, improper disposal of sewage, infestations of rodents and insects, and substandard, crowded, and/or inadequate housing.[6]

  Lack of toilets, potable water, and hand washing facilities in the work place.

  Social dysfunction due to overcrowding in labor camps (i.e., substance abuse, child abuse, domestic violence, sexually transmitted diseases).

  Educational disruption due to constant mobility and urgency of work.

  Constant stoop labor.

  Accidents involving large and small farm equipment.
- Hazards for children in the fields.
- Highway accidents involving migrating families due to poor equipment or fatigue.[3]
- Inability to qualify for basic health and disability benefits such as Worker's Compensation or Social Security due to exclusion from legal and legislative definitions.

  Illnesses and hazards commonly suffered by farmworkers and their families include dehydration, viral infections, frostbite, minor headaches, gastrointestinal disorders, dermatitis, severe depression, chronic migraines, musculoskeletal problems, miscarriage, birth defects, cancer, loss of eyesight, loss of limb, and loss of life.

WORKING CONDITIONS

The decline of small family-run farms and the rise of agriculture as a large-scale business has contributed to the abuse of seasonal farmworkers. Basic worker protection standards enacted for other industries in the early part of this century exempted agricultural workers. Loopholes which discriminate against farmworkers were designed to safeguard the economic stability of the agricultural industry, rather than to protect the health and welfare of the farmworker.

The evolution of worker protection arose from the industrial movement in the United States. The regulation of age and working hours for children, the reduction of dangers created by equipment or closely confined working areas, ventilation of sweatshops, and unionization were all important achievements during the Industrial Revolution. In contrast, the small family farm, as a work place, was viewed as a mecca of fresh air and "God's green earth." But working conditions for farmworkers have always been brutal, including working from dawn to dark in damp fields and orchards, stoop labor, long hours in wet clothing, and exposure to the elements. These circumstances result in a host of conditions ranging from dehydration to chronic health problems to death. Although agricultural workers comprise only 3 percent of the work force, they account for 14 percent of work-related deaths.[1]

Recently, field sanitation (1987) and environmental worker protection standards (1992) have been promulgated to cover agricultural workers, but these new standards contain more loopholes and are consequently nearly impossible to enforce. For example, farms that employ fewer than eleven workers are exempt from field sanitation laws. In 1990, OSHA conducted field inspections and found that 69 percent of farms subject to the law were in violation. In 1989 the Department of Labor was able to inspect only 1.5 percent of work places covered by the Fair Labor Standards Act. The loopholes in the law and the deficiencies in enforcement led the General Accounting Office to conclude in 1992 that farmworkers are not adequately protected by federal laws.[2]

The lack of basic requirements for farmworkers, such as access to potable water and toilet facilities, has been linked to high rates of communicable disease. Dr. Jesse Ortiz participated in OSHA's hearings on field sanitation for farmworkers in 1984. He reported that farmworkers are at 20 times greater risk of parasitic infection than the general population, 11 times greater risk of contracting gastroenteritis and infectious diarrhea, and 300 times more likely to develop infectious hepatitis.[9] Farmworkers have also been found to be 3 to 5 times more likely to develop urinary tract infections due to the lack of toilets and drinking water.[3]

Worker's Compensation is another benefit farmworkers are denied. When workers are injured on the job or disabled after years of repeated exposure, only limited numbers qualify for Worker's Compensation or disability benefits.[2,3] The single most effective achievement on behalf of this population

would be the assurance that they receive the same protections available to industrial workers.

PESTICIDE EXPOSURE

Pesticide exposure results in both acute and chronic health problems. The impact of acute poisoning is widely recognized; however, little is understood about the long term effects of repeated low-level exposure. Ezequiel Morfín describes his situation:

> *... the chemicals are affecting the community a lot, and there are no studies that have been done over a long period of time. I've been a field worker and I've worked with chemicals. And they produce long-term allergies, and they cause colds that last two or three years to get rid of [sic]. We believe [it is] because of the chemicals ... when I go to the places where they have used chemicals, right away I break out. And so I have been contaminated."*[11]

Some studies reveal multi-generational effects of pesticide exposure among farmworkers and their families. Of significant note are the clusters of cancer and birth defects which have been documented in Earlimart and McFarland, California.

Heavy reliance on the use of pesticides and fungicides in the agricultural industry supports the volume production of inexpensive, blemish-free food which the American consumer has come to demand. The Environmental Protection Agency (EPA) estimates that 300,000 farmworkers suffer acute illnesses and injuries as a result of pesticide exposure each year.[3] Lack of effective testing methods to verify exposure as the cause of a symptom means that physicians are not able to rule out other possible causes.

The EPA published the final rule on worker protection standards and hazard communication for agricultural workers on August 21, 1992. "EPA has taken a three-pronged approach to protecting farmworkers from pesticides on the job. Provisions in the new rule will attempt to prevent exposure to pesticides, mitigate exposures that do occur, and inform employees about the hazards of the pesticides they work with."[4] Under this new rule, employers are required to provide training to all workers within 16 days after an employee begins work. Training must be documented and repeated once every five years, or when a new hazard is introduced into the work place. However, exemptions to certain aspects of this rule (e.g., reentry intervals) have already been granted to the cut flower and fern industry on the basis of their request citing economic hardship. Other requests for exemptions may be forthcoming.[5]

Testimony from farmworkers at public hearings repeatedly underscored the fact that knowledge of what chemicals have been applied and of required reentry intervals is helpful, but that farmworkers cannot sacrifice their jobs and must still do whatever work they are told to do in order to feed and house

their families. Estevan Sanchez testified before the National Advisory Council on Migrant Health,

> *We have seen that the farmers don't take the measures that should be taken as far as the spraying because ... they spray in one field and they will bring it right next to us to work. So it's not very far away from the spray. And a lot of times they would have to wait four or five days so that the strength of the spray [would diminish] and other times they don't wait that long because they need to do the work. And so they decide to have the people go to the work as it is.*[12]

To effectively implement measures to protect farmworkers and to understand the situation with which they must contend, farmworker input is needed. Failure to obtain their testimony will result in inappropriate programs that are inadequate to accomplish the goal of worker protection.

HOUSING

As reflected in the recommendation and background statement on housing, this is a critical issue for farmworkers. This issue must be included in any discussion of environmental/occupational risks. Farmworker housing, where it exists, is substandard and exposes occupants to physical injury, sanitation-related diseases, increased risk for infectious diseases, parasites, tuberculosis, and a host of other preventable disorders. One farmworker testified to the National Advisory Council on Migrant Health that cabins are sometimes located within the fields, where farmworkers cannot see notices posted by the grower regarding pesticide applications.[13] For more information on housing issues, please refer to the Housing recommendation and background statement.

MIGRATION

The risk and stress factors of migration are difficult to document, yet professionals who work with farmworkers on a regular basis are very familiar with the impact of migration on the individual lives of farmworkers and their families. The seriousness of this impact is frequently dismissed by the general public: "Farmworkers like to travel—they are like gypsies," "They are used to these conditions, why they're better off here than they are at home," "It's like going camping." The reality is that farmworkers are just like other humans, with a need for stability, continuity, privacy, and security in their lives.

The impact of constant migration over the span of a child's early developmental years can be very detrimental. In addition to the actual physical risks involved in constant traveling of the highways, like breakdowns and accidents, there are also psychosocial risks related to hunger, long hours of work, crowding, homelessness, lack of ability to establish friendships and relationships, the stress of travel and poverty on their parents, and academic interruptions. Even if a family manages to provide a secure environment in

spite of the occupational necessity of traveling, exposure to the dysfunction of other migrant families often has a serious impact.[7]

Although the majority of farmworkers travel as family units, there are also large numbers of single males who leave their families in order to support them. These males, far from their homes, are vulnerable to exploitation by unscrupulous crew leaders and local residents who would involve them in the sale and use of drugs and alcohol and prostitution.[8]

The economic and political forces which impact farmworkers are beyond the control of the workers themselves. The environmental and occupational exposures they face daily are so closely intertwined they cannot be looked at as separate entities. In a presentation to the Surgeon General's Conference on Agricultural Safety and Health, Dr. William Popendorf stated, "Adverse health effects are the culmination of an often complex chain of events beginning with the agent emanating into the working environment from a sometimes nebulous source and traveling through a physical pathway to create [health problems]." Certainly the spectrum described herein constitutes such a complex chain of events. Dr. Popendorf also cites the paradigm of anticipation, recognition, evaluation, and control. It is truly through the application of each of these steps that occupational and environmental risks for farmworkers can be effectively reduced.

Reducing environmental and occupational risks for farmworkers requires the full involvement of all organizations with responsibility for agricultural laborers. The Department of Health and Human Services, the Social Security Administration, the Department of Labor, the Department of Justice, the Department of Housing and Urban Development, and the Department of Agriculture's Rural Economic and Community Development Services must all be responsible for and responsive to the needs of farmworkers. The Council's recommendation that the Secretary combine forces with these entities to improve conditions for farmworkers is essential because it will take a combined effort to challenge the status quo.

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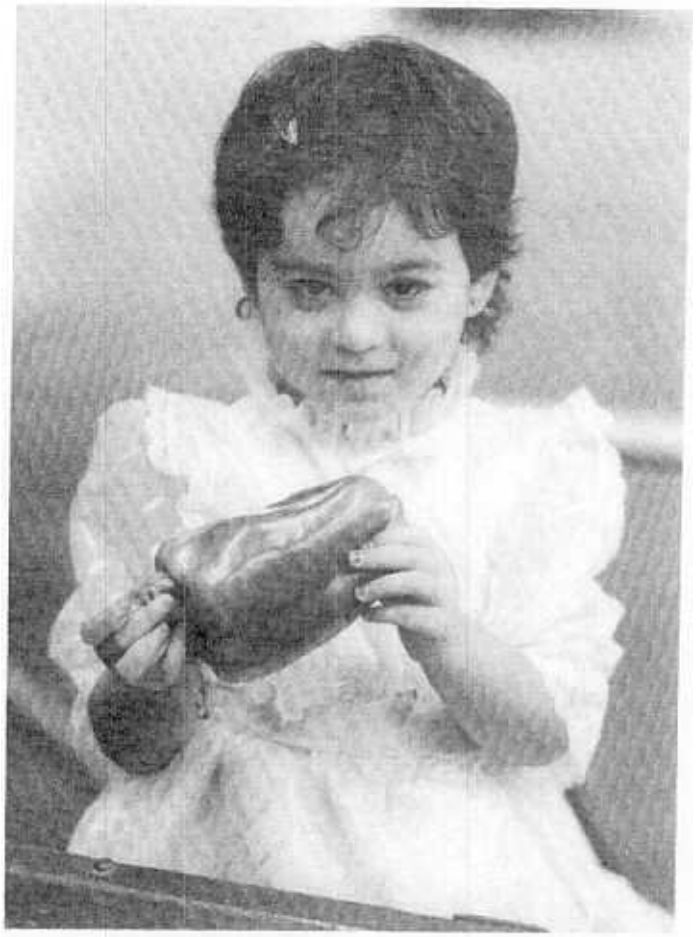


APPROPRIATIONS AND AUTHORIZATIONS

Background: APPROPRIATIONS AND AUTHORIZATIONS

"The work is well begun... Still the need has not ended. Service coverage remains weak in many of the areas where projects are now receiving grant assistance. Three-fifths of the counties identified as migrant home-base or work areas are still untouched."[2]

HISTORY

During the late 1930s and early 1940s, the Farm Security Administration (later part of the Department of Agriculture) constructed Farm Security Camps at major points of farm labor demand. The camps provided housing, basic health care services, and referrals to physicians or hospitals. In 1946 the Department of Agriculture's farm labor program provided health care to more than 100,000 workers. This program was funded almost wholly by federal appropriations, and became a casualty in 1947 when Congress terminated all wartime emergency programs. One observer comments, "What Congress failed to note at the time was that the needs of seasonal farmworkers amounted to a continuing emergency that started before the war and lasted afterward."

Change began slowly, primarily at the state level, in the 1950s. Conditions for farmworkers went almost unregulated by federal law until the passage of the Migrant Health Act. This Act, signed by President John F. Kennedy on September 25, 1962, authorized the delivery of primary and supplemental health services to farmworkers. Funded under Section 329 of the Public Health Services Act and administered by the U.S. Department of Health and Human Services, the Migrant Health Program has been a strategic partner in the delivery of health care services for thirty years. The Migrant Health Act was devised to make health care services accessible to migrant farmworkers and their families by helping states and local communities adapt their existing health care system to meet the unique needs of this population. The initial appropriation of $3 million was intended to pay for only part of the project costs; it was hoped that contributed funds from public and voluntary sources would be used to the fullest extent possible.

In the first year, 52 organizations were approved for Migrant Health Program support. According to the Senate Subcommittee on Migratory Labor in 1967, "Service coverage remains weak in many of the areas where projects are now receiving grant assistance. Three-fifths of the counties identified as migrant home-base or work areas are still untouched."[2] Grants under the Act in its first few years were generally small, and had to be supplemented with other resources. Beginning in 1965, "each time that the term of the legislation neared its expiration date, Congress extended the law and increased the authorization of funds. However, actual annual appropriations nearly always lagged behind the authorized level. Thus in 1983 the authorized ceiling was $47 million but the actual appropriation was $38 million."[1]

It is estimated there are between three and five million farmworkers and their families. Today there are over one hundred migrant health projects whose clinic sites provide services to an estimated three million farmworkers and their families in 42 states and Puerto Rico.[3] This might appear to be progress, but these heavily used projects are still able to serve less than fifteen percent of the estimated migrant and seasonal farmworker population in need. The misfortunes of the farmworker are far-ranging, and are reflected in their overall poor health status. Farmworkers require a health care delivery system which offers effective, migrant-specific, culturally tailored health care.

CURRENT FUNDING

Studies have shown that the migrant population is at greater risk and suffers more problems than the general population of the U.S. Since 1962, migrant health centers have struggled to serve farmworkers, but the ongoing battle to provide services to this population is being lost.[4] A 1988 Report of the Labor and Human Resources Committee noted that:

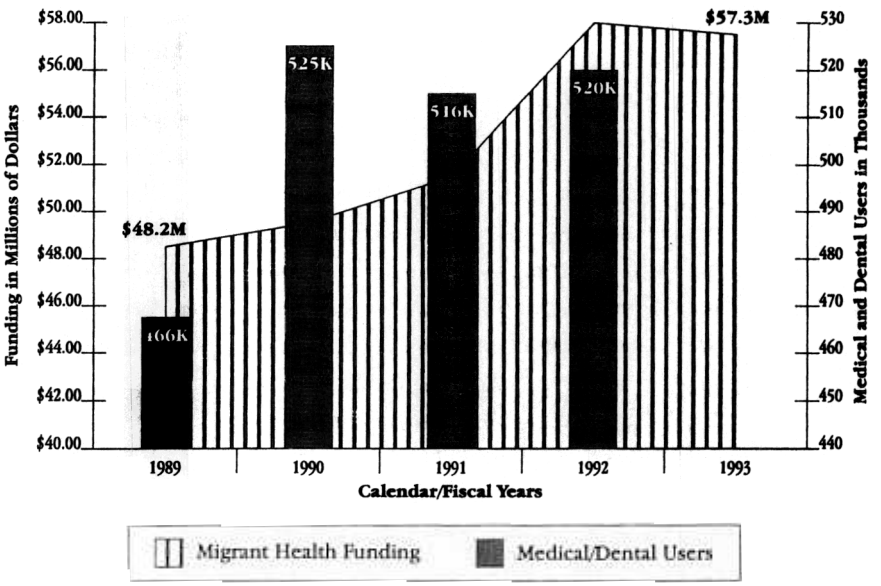
> *The Committee is aware that [case management] services—which were once an integral part of a typical health center's service package—are today offered by fewer than one-third of all C/MHCs. In most cases, these services were either reduced or eliminated due to funding constraints... [yet] these very services have been cited by numerous independent experts... as being particularly important in serving high-risk, hard-to-reach populations ... [It] is the Committee's desire that, as additional funds are made available for these programs through future appropriations, priority should be given to the development or restoration of the patient case management services at existing health centers.*[5]

As noted by the National Association of Community Health Centers, "Severe limitations on the federal budget in recent years have seriously affected [community and migrant health] center growth. Federal policy makers have attempted to aid centers in a number of ways... yet the demand for services far outpaces these small gains. Yet the mere existence of health centers has been an aid to local economies. By stressing preventive care in the communities they serve, indigent reliance on hospital emergency rooms has been markedly reduced. Immunization and prenatal care rates are considerably higher among eligible C/MHC users than comparable community residents who do not use health centers."[6] Migrant health centers need the flexibility to utilize PHS 329 funds for implementation of service delivery models which are most effective for farmworkers, even if those models vary from the traditional medical model. This includes the use of lay workers, perinatal outreach, special clinician recruitment projects, etc.

Rapidly escalating medical costs have made the funds available for farmworker health services less and less adequate. For example, "The 1984 migrant health

appropriation was three times the amount in 1970. However, per capita health expenditures for the nation during the same period increased 3.5 times." Figure 1 depicts the appropriation history for Migrant Health; if the program had kept pace with the consumer price index for medical costs, the current appropriation would be $87.9 million. The $100 million recommended appropriation includes this figure plus additional funding for comprehensive perinatal services for farmworkers.

Figure 1. Migrant Health Program Total Funding and Medical/Dental Users: 1989-1993



A 1985 report published by the National Migrant Worker Council aptly stated,

> *To expect a minimally funded program to meet all the health needs of a deprived population in a time of high and rising costs is to expect the impossible ... At every level of operation, the [Migrant Health] Program generally lacks the funds and the staff required for full effectiveness in building and maintaining the kinds of coalitions with other public and voluntary groups that would bring the effectiveness and scope of service of grant-assisted projects to their maximum.*[7]

An example of the problems clinics face from funding shortfalls is demonstrated in the testimony of Jorge Miranda, a farmworker board member of a migrant health center. He described how his clinic obtained a van, but could not pay for a driver to transport patients from the fields to the clinic.[11] The extent of farmworkers' unmet need for basic health care services is not only a national disgrace, but also a national challenge. In order to improve the overall health status of farmworkers in this country, a major appropriation increase for the Migrant Health Program is necessary.

CONCLUSION

In the late 1960s, Congress expressed the desire for the eventual expansion of programs for the general population to cover services to farmworkers. Congress noted, "However, for the foreseeable future ..., this program, because of its importance to the health of the American people, should be considered as a permanent and separately identifiable program... ."[8] By 1985, a new report indicated that, "Nationally, ... the Migrant Health Program serves as a nagging reminder of the continuing health problems of migrants... The separately identifiable health service program first envisioned by Congress ... seems as much needed today as it was in the beginning."[7] And yet legislation proposed as of the fall of 1995 recommends that Public Health Service funded programs for farmworkers, the homeless, and other vulnerable populations be folded into one Community Health Center program with joint authorization.

The conclusion reported by the Public Health Service in 1954 remains pertinent today:

> *Migrants present the gamut of needs for health, education and welfare services—needs which are intensified by their economic and educational status and by the fact of their migrancy. Challenges to official and voluntary agencies lie in finding ways to coordinate required services locally and to make these services continuous as migrants move from place to place... At stake are the health and welfare of... people who make a vital contribution to our national economy as well as to the health and welfare of the communities through which they move.*[9]

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HOUSING

Background: HOUSING

"Now there are a lot of people who are making a living in the same way [as farmworkers] but are unable to find adequate housing, consequently having to live under the trees. What's even worse, the foremen even charged them for sleeping under the trees."[14]

PROFILE

Farmworkers live in the most deplorable conditions and are taken advantage of at every opportunity. The following are of some the problems they face:

- When housing is available, several families frequently live in one structure, sometimes numbering fifteen or more people in one or two rooms.
- Frequently there is no electricity or plumbing.
- When housing is not available, they live in boxes, cars, garages, caves, or in the fields and orchards where they work.

  Available housing is often near or in the fields, making farmworkers live with pesticides in their food and clothing and on their persons twenty-four hours a day.

  There are rarely any laundry facilities.

  If they seek housing in town it is already too expensive and the prices usually go up for farmworkers.
- In many instances, there is no heating or cooling.
- They fear complaining about the housing conditions because they could lose their jobs.
- If their housing is linked to their job, when the job is finished they are instantly homeless and unemployed.

Seasonal farmworkers are an essential part of the farming communities where they temporarily work and live. They are the crucial and primary work force who harvest the seasonally intensive, large-scale, diverse produce across the U.S., doing hard labor for very small wages under stressful and dangerous conditions. Farmworkers are employed in every state in the country. In some areas of the U.S. they help to harvest over half the produce in the community. Due to the seasonal nature of crop production, these communities cannot support permanent work forces large enough to harvest their crops. Farmworkers and growers are interdependent; each would suffer in the absence of the other. The country as a whole also depends on cheap farm labor to fill the markets with a variety of inexpensive, fresh produce.

Due to these circumstances, farmworkers must constantly travel during harvest time, living in whatever housing is available. Frequently, there is either

no housing at all or the housing available is deplorable, having no plumbing, electricity, or even a decent roof.[17,18] These appalling conditions are compounded by the fact that farmworkers are frequently accompanied by their families, many of whom must also work in the fields. Consequently, whole farm working families migrate across the country, living in whatever shelter they can find and afford.

Traditionally, temporary housing during the peak crop harvesting and packaging seasons has been met by growers, in the form of labor camps.[1] These labor camps have never been adequate. A U.S. Department of Agriculture Handbook published in 1970 stipulates that the basic requirements of housing for seasonal farmworkers include well-built houses made of materials appropriate to their uses, with adequate lighting and ventilation, access to safe water, and adequate size for the number of people inhabiting each house. The handbook also suggests landscaping the grounds and providing recreation areas and child care facilities. In light of the housing currently available, these standards are meaningless.

HOUSING CONDITIONS

Farmworker Estevan Sanchez described the predicament farmworkers face: "Well, when a farmworker arrives he arrives to the field, and the persons don't just give housing for one person. [There are] three or four people in one single cabin, or we should say maybe in one room."[11] A study of actual migrant farm laborer housing undertaken on behalf of the Department of Health, Education, and Welfare in 1978 revealed a prevalence of housing that was overcrowded, unsanitary, unsafe, and sometimes failed to even shelter the occupants from the elements.[2] The housing sampled in the study ran the gamut from needing repair to being wholly uninhabitable. Of the camps sampled, 53.5 percent required repair and 5.6 percent required replacement. 71.8 percent were judged sound, while 26.8 percent were deemed deteriorated and hazardous.

The average number of rooms in a single family dwelling was between one and 2.6, with the average dimensions of rooms being 10' x 12' to 12' x 15'. Indoor running water was available in only 64.8 percent of the camps; 21.1 percent relied on privies for raw sewage disposal, while an additional seven percent resorted to a combination of privies and portable toilets to meet this need. Two thirds of the units lacked any kind of heating system, although they were located in latitudes where heating was necessary. Most of the facilities were inadequately ventilated and did not meet fire escape standards, having only one exit. Bedrooms usually lacked the capacity for the number of individuals housed in each unit, and laundry facilities were generally unavailable.

In a large number of units, kitchens doubled as sleeping quarters. Of the kitchens surveyed, half had no sink, a quarter had no refrigerator, and 60 percent had improperly vented stoves. Central bathroom facilities often lacked privacy partitions between toilets and frequently did not provide enough toilets to be accessible to the number of workers on site.

Barracks-type units designed to house large numbers of single men scored even worse, with 28.8 percent of the shelters not providing basic protection from the elements, and over 50 percent of the barracks not providing heat. The barracks were found to be overcrowded, and no two-story barracks building met fire escape standards. Even facilities that were licensed, and therefore presumably monitored, showed evidence of fly and mosquito breeding, rodent harborage, and trash burning, as well as broken windows, torn screens, and damaged steps, roofs, foundations and shells. Sanitation in the form of garbage storage and sewage disposal was also inadequate.[2]

The health risks of these housing conditions are alarming. Cold, damp interiors can produce otitis and respiratory infections, which occur more frequently among farmworkers than in the general population.[3] The presence of a toilet in a sleeping area is associated with an increased incidence of gastrointestinal distress, anorexia, and gastroenteritis. Substandard and unheated rooms manifest an increased incidence of measles and upper respiratory infections. Single-bed usage by families creates increased incidence of impetigo and emotional distress. Multi-use sleeping rooms are associated with an increased incidence of bronchiectasis, tuberculosis, influenza, and tonsillitis. The lack of laundry and hygienic facilities leads to bathing and laundering in kitchen sinks, exposing food preparation surfaces to the pesticides and fertilizers that workers are exposed to in the fields.[2] One worker commented, "If we go to a field, we can see cabins with eight or nine men living together, and these people have to cook and sleep in one single place ... do you think that makes us susceptible to illnesses or not?"[12]

REGULATION AND ENFORCEMENT

In 1978 the deplorable state of migrant farmworker housing was blamed on insufficient monitoring by regulatory agencies. OSHA was the primary federal regulatory authority in charge of monitoring migrant farmworker housing, and was considered to be doing a poor job due to a lack of personnel and to confusion concerning its mission in regard to migrant farmworker housing.[2] Since that time, other agencies, most notably the Department of Labor Wage and Hour Division, have also assumed regulatory authority over farmworker housing, enforcing regulations more stringently and levying fines for substandard housing. Ironically, this has led to deterioration rather than improvement in the standard of living for migrant farmworkers since the assessments of 1978.[4] With stricter enforcement of the regulations, many growers or camp operators are forced to choose between facing fines for violations and the cost of renovations, or closing the camps. Due to the cost, many are closing their camps.[4] Jesus Tijerina, a crew leader, testified, "In the last year five camps in this area have closed. This means that more than 150 units have been closed. Usually in a unit you can have a family of five. The work has continued as before and the same amount of migrants keep coming back every year."[5]

In areas where housing is only in use for part of the year, as is the case with most migrant farmworker housing, loan programs for farmworker housing

(Sec. 514/516 Farm Labor Housing Program administered by the Rural Economic and Community Development Services) do not meet the needs of growers and operators. In the absence of some type of affordable financial assistance, most growers are unable to provide for the housing needs of the migrant farmworker population. It is estimated that fewer than 5,000 new units have been built since 1980.[6] Yet, since the end of the 1990 growing season, Colorado alone has witnessed the closing of almost 40 percent of its grower-provided housing units.[4] A Colorado vegetable grower told the National Advisory Council on Migrant Health, "Since a year ago it was my policy to burn all the houses down because there was no way that I could comply. This kind of pressure drives me against the wall and I wonder whether it is really worth ... caring for the human element."[7]

OTHER BARRIERS

The seasonal farmworker population is impoverished and comprised primarily of minority populations.[2] The U.S. Department of Labor reported in 1991 that seasonal agricultural workers received a median hourly wage of $4.85.[9] However, when migrant farmworkers cannot find lodging in labor camps they must seek it privately. In the rural areas where they work there is a shortage of private housing and private housing is not subject to federal regulation. The private housing that is available to migrant workers tends to be substandard and expensive. One worker noted, "Right now we are looking for apartments, and barely make [enough] to pay the rent. We pay $375 per month and they also want a deposit of $250 per apartment, $100 for gas, $50 for electricity. So you need $750 to get a house. It takes three weeks to make that much to pay the bills."[8] Frequently, the workers find themselves in worse dwellings than in the camps which were closed, yet the seasonal population growth in these areas puts even this squalid, overpriced housing at a premium, leaving many with no housing at all. The only alternative to expensive, poor-quality shelters is living in a car or in the open.[4] One woman told the National Advisory Council on Migrant Health, "A lot of people live in the streets, or underneath a tree, underneath a bridge. Sometimes they even are staying there in the winter..."[13]

Farmworkers also frequently meet resistance to their presence in private neighborhoods in the form of hostility or price gouging. In one case, seventeen individuals shared one run-down two-bedroom house, on which they were marginally able to afford the rent. At their current economic level, many migrant farm laborers will not be able to afford to continue working the crops in the absence of free or subsidized labor camps that have been provided by growers in the past.[4]

The phenomenon of migratory workers engaged in temporary work is no longer limited to rural areas. A new population of migratory temporary day laborers is being recognized in urban areas. In these cases, there are no traditions to support their presence and many communities are rejecting them whether they are seeking work or seeking shelter. In Orange county, California, these individuals frequently have no conventional shelter, but live

in makeshift camps of cardboard, wood, and plastic hidden in canyons near towns. The county health department is routinely called to close and bulldoze the camps for sanitation violations. No alternative shelter is provided and some citizens groups have gone so far as to attempt to limit funding for charitable organizations that offer aid to these workers. Yet, at the same time, it is acknowledged that there is a need for their labor.[10]

CONCLUSION

The deplorable state of housing for migrant workers is an accelerating crisis that will have a profound impact on both employers and workers, with deep implications for the agricultural economy and the economy as a whole. Poor housing is rapidly becoming non-existent housing. Without decent, affordable housing, fewer workers will be able to make the seasonal work migrations, and those who do will face housing conditions worse than those of the previous decade. Without the necessary seasonal labor provided by migrant farmworkers, growers will not be able to maintain their current rates of production, and will be less able to afford to provide and maintain adequate housing for the migrant farmworker population.[4] The Rural Economic and Community Development Services, Department of Housing and Urban Development, Department of Agriculture, and Department of Health and Human Services are in a position to significantly improve the migrant worker housing situation. If they coordinate their efforts and resources we may draw nearer to the time when safe and adequate housing will be available for our migrant work force. Meanwhile, the migrant farmworker housing situation is caught in a downward spiral.

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RESEARCH

Background: RESEARCH

The available information regarding farmworkers in America generates as many questions as it does answers. Who are migrant farmworkers? How many of them are there? Where do they come from? What is the state of their health? What are their living conditions?

The current literature offers conflicting and piecemeal answers to the questions above. Current, comprehensive, nationwide studies of the migrant farmworker population are lacking.[1] Much of the research on migrant farmworkers is seriously out of date, having been done in the 60s and 70s.[2] It is generally acknowledged that census figures are not reliable indicators of the actual numbers of migrant farmworkers,[1] and the tabulation methods of other agencies that count farmworkers result in widely varying totals.

Regional information reveals the migrant farmworker population to be at high risk for health problems and frequently to be in distress.[3] While studies at the local, state, and stream levels may be useful for planning in specific areas, these studies "... have limited applicability to the wider farmworker population. Yet not infrequently, the results of these studies are used to represent the farmworker population at large."[4] But migrant farmworkers are a mobile population with a shifting composition, and we lack the documentation to accurately assess the needs of the migrant farmworker population as a whole.[1] Because the health problems of migrant farmworkers are inter-related with the other details of their lives, health studies frequently provide background information on the group of farmworkers being observed. But these studies tend to be local or regional in nature, and thus are not representative of the total migrant population.[1] As of 1986, the only national reporting system to track health data among the migrant farmworker population was the now-defunct Migrant Student Record Transfer System, which tracks the health and academic records of students. No program exists to track this information among the adult population.[1]

POPULATION

Many different government agencies have attempted to number the migrant farmworker population, including the Census Bureau, the Department of Labor, the Migrant Health Program, and the Department of Agriculture. The results of these studies place the migrant farmworker population anywhere between 159,000 and five million. The huge discrepancy in these totals is due to the utilization of different counting methods and differing criteria on who is considered a migrant farmworker by the agency. The census count of migrant farmworkers is considered unreliable because it is collected in April and categorizes an individual's employment according to the job they held most recently within the last two-week period. The census is conducted before most agricultural activities employing migrant farmworkers have gotten underway for the year. The job that a migrant worker held in the last two weeks before the census may not reflect his or her employment for a significant part of the

year as a migrant farmworker.[1] Other agencies may count workers, but will not include their dependents who travel with them and are subjected to the same living conditions and health hazards as the workers. Different agencies also adopt varying standards in determining what constitutes migrant farm work. The fact that migrant farmworkers are a transient population increases the difficulty of counting them accurately.[5]

Also a factor in the comparison of statistics across agencies is the lack of a standard definition of terms. Former Vice Chair of the National Advisory Council on Migrant Health Charlene Galarneau explains,

> *In the farmworker health context, this assumed migrant difference [from other populations] has also come to characterize seasonal farmworkers. Initially authorized to serve migrant farmworkers and their family members, [the federal Migrant Health Program's] 1970 reauthorization contained an expansion of its service population to include seasonal farmworkers and their family members.*[4]

The Migrant Health Program's program data, therefore, includes data on the combined migrant and seasonal populations. Other programs may report data on migrant or seasonal workers only, or may have definitions of "migrant" and "seasonal" which differ significantly from the definition used by the Migrant Health Program. Finally,

> *Farmworkers are a diverse population... In the absence of adequate information, farmworker health care services planning, delivery, and evaluation is necessarily based on weak generalizations and assumptions about farmworker health care needs. Such generalizations provide little guidance in the prioritization of needs and in resource allocation. These generalizations and assumptions are often made in the language of difference which obscures farmworker diversity and gives us the impression of having greater knowledge about farmworker health than we actually have.*[4]

DEMOGRAPHICS

The composition of the farmworker population is also difficult to determine. The ethnic composition of this population fluctuates and is now predominantly Hispanic, but also includes African-Americans, Native Americans, Creoles, Asians, and Whites. The same factors which make it difficult to count migrant farmworkers also make it difficult to precisely categorize them ethnically or to accurately determine their downstream point of origin. But all of these factors can influence an individual's health status and ability to access the health care system.[1] For example, if a clinic can be reasonably sure that there will be no Creole speakers in their client population, there is no need to allocate funds to recruit Creole-speaking staff.

Conversely, if that same clinic incorrectly anticipates having no Creole clients and then gets a significant number of them, the clinic will not be prepared to effectively deliver health care services to them. A clinic must know who its clients will be and have some background knowledge about their problems to be able to effectively allocate its resources.[1]

HEALTH STATUS

Statistics on the incidence of disease in the migrant farmworker population reflect vast discrepancies. The Interstate Migrant Education Task Force stated in a 1979 publication that the death rate among migrant farmworkers from influenza and pneumonia was twenty percent higher than that of the average population, and that the death rate from tuberculosis was 25 times higher.[3] An article about migrant farmworkers published in 1978 stated that the death rate among farmworkers from influenza and pneumonia was 200 percent higher than the national average, while the death rate from tuberculosis was 250 percent higher.[7] Both of these publications refer to "migrant farmworkers." We do not know the source of the information in either publication; we do not know if these figures were misquoted by one party or the other, or if in different parts of the country both sets of figures might be correct. The introduction to the Interstate Migrant Education Task Force publication quotes the President's Commission on Mental Health that, "... much of the data frequently quoted in reports on the health needs of migrant farmworkers is suspect, and there is a lamentable tendency to pass along such data from one report to another without current documentation as to its validity."[3]

Similar studies conducted by separate agencies in different migrant streams may produce different results. However, there is usually insufficient data on the populations being studied, or on the study methodology itself, to accurately determine what variables produce the conflicting results.[8] The data from local and regional studies is usually insufficient to justify extending the findings to the whole migrant farmworker population.[5] However, "We need not make another common assumption, that it is impossible to obtain reliable health data on farmworkers. A significant population-wide effort has not yet been made."[4]

Two separate studies on the health and mortality of migrant farmworker children were conducted in North Carolina and Wisconsin.[9,10] The North Carolina study found an infant mortality rate among migrant farmworker children of 30 deaths out of 1,000.[9] The Wisconsin study discovered an infant mortality rate of 29 out of 1,000, but also revealed that 45 out of 1,000 migrant farmworker children die by the age of two, and 46 out of 1,000 die by the age of five.[10] The national infant mortality rate was cited by both studies as 14 out of 1,000. The North Carolina study does not track the infant mortality rate of migrant farmworker children past infancy, so we do not know how children in North Carolina fare after infancy compared to the migrant farmworker children in Wisconsin. Neither of these studies indicates what the conditions actually are for migrant farmworker children across the nation.

The Wisconsin study cited difficulties in the assessment of mortality and health statistics among migrant farmworkers. Vital records such as birth certificates did not list the occupation or ethnicity of parents, so the information could not be compiled from these records. The demographic data from the National Center for Health Statistics also failed to identify migrant farmworkers, and so could not be used for migrant studies.[10] Other sources cite problems in ascertaining death rates among the migrant farmworker population since no states list migrant status on death certificates.[5] The difficulty in obtaining migrant statistics from registrations makes it necessary to obtain them through surveys.[10] This method of data collection is complicated by the fact that many migrant farmworkers are fearful of dealing with officials.[1] These factors make it difficult to scientifically determine whether migrant farmworkers suffer from the same health problems as other impoverished populations or if there are migrant-specific ailments brought about by their working and living conditions.[5]

A 1990 analysis of data collected from migrant health centers in the midwestern migratory stream by Alan Dever provides the broadest picture to date of farmworker health status. The study clearly indicates that the migrant farmworker population is at greater risk and suffers more problems than the general population in the U.S. The study's author notes, "Factors such as poverty, malnutrition, infectious and parasitic diseases, poor education, a young population, and poor housing equate to a highly vulnerable population in need of resources... The need for developing a health policy and research agenda for migrant farmworkers in this decade is evident."[11] A review of literature published between 1966 and 1989 pertaining to the health of migrant farmworkers was conducted by George S. Rust, MD. He determined that the health status of migrant farmworkers has not been well measured. According to Dr. Rust's assessment, questions regarding migrant farmworker health remain unanswered on the following issues: population characteristics, mortality and survival data, perinatal outcome data, chronic disease data, occupational risk, nutritional factors, health-related behaviors, and accessibility to health care.[5]

Most cancer epidemiological research in agriculture is focused on owner/operators. Preliminary research of the National Cancer Institute (NCI) indicates that farmworkers suffer an excess of cancers of the buccal cavity, pharynx, lung and liver. Again the lack of data is cited. NCI indicates that cohort studies of farmworkers are needed to gather cancer information. Such studies would require identifying a cohort of farmworkers for which historical medical records are available, due to the relatively long latency period for cancer which needs to be investigated. The difficulty in conducting such studies will lie in tracking the mobile patient cohort being observed. NCI recommends identifying a patient cohort of farmworkers with historical medical records, investigation of farmworker cancer among children (including in utero), and developing a series of questionnaires for use in screening farmworker patients for inclusion in a research cohort.[13] The

Council is pleased that NCI has funded organizations to conduct farmworker epidemiologic research.

Many regional and local studies have been conducted on migrant health issues, and on a local scale they are useful. But the limited scope of these studies makes them questionable as indicators of the health status of the migrant farmworker population as a whole. To date, most of the information comes from clinic-based research, which is time-consuming and costly and still leaves the major questions regarding the health status of migrant farmworkers nationwide unanswered. One thing which does become apparent from clinic-based research is that the primary care function of the clinics is desperately needed by their client populations. Clinics need their limited resources for primary care, and should not have to make their funding do double duty for both treatment and research.[1] One migrant health project representative stated, "There is tremendous value if we can really document how the health needs are greater for migrant farmworkers... There is also tremendous potential for generating more funding if we can show how we're having an impact on the health of these people... It takes funding to do that. [But] then we get into the bind that if we've got inadequate funding, how do we support the research agenda without sacrificing patient care?"[12]

CONCLUSION

Accurate information on the migrant farmworker population is required in order to efficiently allocate the resources available to serve their health care needs. This information is also necessary to determine exactly what those needs are at present and to anticipate future needs. Currently, our information on the migrant farmworker population is fragmented, conflicting, and frequently out of date. Research should be both population and practice based in nature, and should be conducted with dollars which are not re-directed from service delivery appropriations.

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