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Health Care Needs of Mexican Migrant Farmworkers in Rural Illinois: An Exploratory Study

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Abstract

Little is known about health care needs of Mexican migrant farmworkers (MMFW). Controversy is found in the literature regarding the extent to which cultural beliefs influence access to scientific health care. A descriptive study of 39 families of MMFW was conducted to determine their health care needs and the extent to which medical services were impeded by their migrant status and cultural beliefs. A Spanish interview schedule was developed and pilot tested. Data regarding health problems, health services, health education, and beliefs in folk medicine were collected.

MMFW perceived communication barriers, unfamiliarity with community medical care services, and conflicts with job schedules as obstacles to seeking medical attention. MMFW believed in, and suffered from, such folk diseases as Mal de Ojo, Caida de la Mollera, Susto and Empacho, and were familiar with folk therapy.

This study found cultural beliefs and practices of folk medicine had little or no interference with scientific medicine. Both types of health care were used simultaneously. Mobility and inaccessibility to scientific health care influenced MMFW to use self-prescribed, over-the-counter medications—including injectable penicillin.

Mexican and Mexican-American migrant farmworkers who follow annual crop routes in the United States have uncertain and limited opportunity for health care. Little is known about the type, extent, or effect of those limitations, especially on those that may be related to cultural differences. This study of a small group of such workers in an Illinois rural county, investigated the influence of scientific and folk medicine upon their health status and health care use.

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It is estimated that the number of migrant workers and their dependents reaches six million (Committee on Aging, 1990). Of those, approximately 63 percent are Mexican-Americans (National Migrant Resource Program, 1991). Little is known about the characteristics and needs of migrant farmworkers (Rust, 1990). Their life is characterized by poverty, lack of education, and poor health (Committee on Aging, 1990). Life expectancy in 1987 was only 49 years, and the infant mortality rate was 125 percent higher than the national average (National Migrant Resource Program, 1990).

Despite the efforts the United States has made in providing health care services to migrant workers, they continue to experience problems accessing the health care system (Sakala, 1987). High mobility, overcrowded living conditions, demanding work schedules, low income, low education, discrimination, language, and cultural barriers may play important roles in migrant workers' health status and health service utilization (Commission on Civil Rights, 1977; 1978; 1983).

Cultural beliefs in folklore medicine continues to be alive among Hispanics of Mexican heritage (Nall, 1967). Empacho, Susto, Caida de la mollera, and Mal de Ojo are common Mexican names for folklore diseases (Clark, 1959; Kelly, 1965; Madsen, 1964). **Empacho** is a folk disease believed to be caused by a ball of undigested food on the wall of the stomach or intestine. Its symptoms are: stomach cramps, abdominal distention, anorexia, diarrhea, and vomiting (Baca, 1967; Madsen, 1964). It is similar to the Anglo concept of indigestion. **Susto** is a folk disease caused by strong emotions, especially sudden prolonged terror (Clark, 1959). Among its symptoms are: high temperature, diarrhea, vomiting, restlessness, lack of appetite, shakes, and loss of energy (Baca, 1969; Madsen, 1964; Nall, 1967; Rivera, 1990). It is similar to the Anglo concept of "shock." **Caida de la Mollera** is a folk disease of infants believed to be caused by the dislocation of the frontal fontanel (Madsen, 1964). Its symptoms are: diarrhea, vomiting, inability to eat, inability to suck, irritability, crying, and inability to sleep (Baca, 1969). **Mal de Ojo** (Anglos call it "evil eye") is a folk disease attributed to magical cause and to which children are thought to be particularly susceptible (Clark, 1959). Its symptoms are: malaise, sleepiness, severe headache, and "tired out feeling" (Nall, 1967). Strangers (including health providers) may avoid inadvertently giving

"evil eye" by gently touching the child. These four folk diseases were often found among the population studied here. There are many others, but those were not frequently encountered among this study group.

There is conflict among researchers regarding whether the use of folk medicine by Mexican and Mexican-Americans is a barrier to scientific care (O'Brien, 1983). Some studies report that folk medicine decreases use of scientific care, while others report no relationship (Higginbotham, Trevino & Ray, 1990; Martin, Martinez, Leon, Richardson & Acosta, 1985; Nall, 1967; Slesinger, Richards & Folk, 1981). This study provides data regarding the perceived health care needs reported by a select group of MMFW in rural Illinois and the extent to which medical services were impeded by their migrant status and cultural beliefs.

Methods

Respondents. Forty-seven MMFW families visited and worked in rural west central Illinois during the corn detasseling period of 1990 and 1991. All were from the Rio Grande valley in south Texas, where they were visited for this study in Texas during fall, 1991. This survey gathered data regarding 166 persons who were members of 39 households (82% of target population). Within these households, 88 respondents were interviewed. Nonparticipants included four families not living in the United States, two families who could not be found, and two families who declined participation.

Characteristics of the household members are shown in Table 1 (Bogue, 1991). These data are answers to initial questions, such as "What language do you prefer to use?" or observations recorded on the interview schedule.

Interview Procedures and Measures. The subjects' employer provided a list of their reported addresses. Phone contact was established with the crew leaders (work supervisors) explaining the study and requesting cooperation. In Texas, personal contact was established with the state coordinators of Project Even Start for Migrant Education, who work with the target population in Texas and Washington.

Data were collected by using a Spanish or English interview schedule, depending on preference of interviewee. The interview schedule was adapted from Preciado's (1984) questionnaire, as well as pertinent questions revealed through a thorough review of literature. The interview schedule was pilot tested during the summer of 1990 for ease in use, clarity, and time to complete with a select group of MMFW.

Interviews were conducted in Spanish, except for two interviewees who were more comfortable with English. When possible a grandparent, parent, and child were interviewed within each household to explore different experiences, values, and attitudes according to age and generation level. Demographic data regarding the family were usually collected from only one member of the family, such as a parent, who would describe the health history of the others including the children.

Household composition was highly variable. To facilitate rapport and avoid bias, the primary respondent was chosen by interviewing the first willing adult member of the household contacted. If other members were present and added information, those data were included also. Value and attitude data were limited to the adults and older children among the farmworkers. More than one person per household was interviewed because for some research questions, experiences and values of each farmworker comprised the units of variation; for others, families and

Table 1

Demographic Characteristics

	Number	Percentage
Age		
1-12	49	29.52
13-20	42	25.30
21-44	59	35.54
45-68	16	9.64
Sex		
Female	81	48.80
Male	85	51.20
Religion		
Catholic	144	86.75
Protestant & Other	22	13.25
Birthplace		
Born in USA	90	54.22
Born in Mexico	73	43.98
Missing data	3	1.80
Language		
Spanish	91	54.82
English	4	2.40
Bilingual	69	41.57
Missing data	2	1.21

(n=166 Family Members)

their members were the units of variation. Extended kinship was prevalent among many workers and families, and in no sense was the sample considered to be random. An attempt was made to include all members of the migrant farmworker group who could be found and who were willing to participate; no one was intentionally excluded.

The interviews were conducted within a 10 day time frame, with an average of four households per day, and 40 minutes per interview. A total of 88 individuals were interviewed.

Interview Schedule. The data were collected using a 10-page list of questions and matrix forms for recording approximately 140 variables and responses regarding demographics, health histories and treatments, experiences and attitudes of self and family members. The questions were asked orally, and the interview schedules were completed by the interviewer, who tailored the conversation flow sequence to the interview schedule.

Data Analysis. The interview schedules were coded for data entry purposes. Units of analysis were sometimes the 39 households, the 88 respondents, or the 166 household members as appropriate to the data (for example, infants were not asked for their attitudes, but their illnesses were included). Using the SPSSx software program, percentages permitted the analysis of perceptions of health care, the use of folklore medicine, and the opportunity for health education. Cross-tabulations were used to determine the relationship of demographic variables with health perceptions, and use and preference of scientific versus folklore medicine.

Results

Health Status and Health Problems. Subjects' health status distribution was not homogeneous; rather, it appeared to be stratified among two segments of the group. Of the 88 respondents interviewed, 54 considered their health status as "excellent" or "good;" these respondents were mostly bilingual, with more than six years of education, and were second or third generation Mexican-American. The remaining 34 considered their health status as "regular" or "poor:" these subjects tended to be first generation Mexican, and spoke little or no English.

The most common health problems reported among the 39 households were dermatological problems, and musculoskeletal ailments such as swollen joints, back pain, and joint dislocations. Degenerative diseases such as heart disease, blood pressure, and diabetes were reported by approximately 20 percent of the households. Table 2 shows the reported frequency of family illness and injury (Bogue, 1991), in answer to the question, "Speaking of your health experiences, could you tell me how frequently you and the members of your household suffer these or other illnesses?"

Table 2

Illness Reports Among Households

Health Problem	# of Households
Skin	25
Colds	24
Headache	21
Swollen joints	20
Back pain	18
Throat	17
Rheumatism	14
Nerves	14
Stomach pain	12
Urinary problems	11
Dizziness	11
Accidents	10
Ear	9
Folk illness	9
Blood pressure	9
Heart	8
Joint dislocation	6
Tooth	6
Diabetes	4

n = 39 Family Households

Use and Access to Health Care Services. Forty-three of the 88 respondents used health services while in west central Illinois. Twenty of them received medical care in the emergency room, 15 visited the County Health Department, and two used physicians' offices. Of those who used the health services, the majority perceived them as excellent. Six received health care from other sources.

Thirty-four of the respondents perceived difficulties seeking medical attention while in west central Illinois. Among the perceived impediments were language barriers, unfamiliarity with community health care services, and conflicts between physicians' office hours and the migrant workers job schedule, and transportation. There were also cases reported in which physicians' offices refused service. These and other impediments were some of the reasons many respondents went to the emergency room first, where they could be certain of treatment, even though they might have had a minor health problem that could have been treated elsewhere. Table 3 shows the influence of language and cultural limitations on the perception of impediments to medical services (Bogue, 1991). These responses were in answer to the questions, "Did you or your household have trouble obtaining medical attention while you were in Macomb?" and "Which of the following problems have you had?"

Table 3

Perceived Impediments to Medical Services in West Central Illinois by Birthplace

Problem	Birthplace USA	Mexico	Total
I don't speak English	1	19	20
I didn't know which doctor to go to	4	14	18
I couldn't lose a day of work	3	12	15
I didn't have transportation	1	5	6
I didn't have enough money to pay	2	4	6
I didn't have anyone to care for the children	2	4	6
The doctors don't see walk-in patients	--	3	3
The appointments dates were too far off	1	2	3
The doctors wouldn't give appointments	1	1	2
I didn't have a telephone	--	1	1
I don't believe in doctors	--	--	--
Other reasons or problems	3	5	8

n = 88 Interviewed Migrant Farmworkers
Not all respondents stated a problem, and several stated more than one.

Folklore Medicine. Folklore medicine was found to be almost universally practiced among this study sample. "Mal de Ojo" ("evil eye"), "Susto" (shock), "Caida de la Mollera" (an infant's fontanelle condition), and "Empacho" (acute digestive distress) were considered illnesses requiring intervention through the services of ritual and cultural healers. Although such beliefs were prevalent, it was found that there was little or no interference of such beliefs with seeking scientific medicine. Rather, both types of health care were often used together, much as some people pray, console one another, or seek counselors while visiting physicians at the same time. There were, however, time sequences of health provider preference and choice related to degree of traditionality.

On the other hand, the lack of physician services often led to an increased use of self-prescribed, over-the-counter remedies—including injectable penicillin. Many of the respondents provided anecdotal accounts of the simultaneous use of hospital, home remedy, prayer, and curandera folk healing by the same individual, with no feeling of contradiction, indicating that each had its place in the healing process.

Table 4 shows how illness was treated and subsequent choices for care (Bogue, 1991). A series of questions asked what illnesses or accidents had occurred to household members in the previous two months; the name of the illness; what had been done to cure it; what had been the result; if treatment was not effective, what was done next?

Although these data were not statistically significant, they offer a tentative answer to the question of how one choice of treatment leads to or interferes with another, by cross-tabulating the choices and their consequences. A pattern of health care sequence was noted. Those whose first choice was medical care treatment were more likely to return to a physician the second time. On the other hand, those who used other sources of treatment as first choice were more likely to move from the less scientific treatment to the more scientific one. If the problem was not solved, medical or over-the-counter medication was the next most likely choice. On the other hand, if the drugstore failed, a curandero or a physician was likely to be consulted.

Table 4

Sequence of Treatment Choices

Outcomes of First Choice by First Treatment

	Cured	Not Cured	Total
Medical	14	5	19*
Drugstore Remedies	23	11	34
Home Remedies	19	6	25
Healer	9	2	11
Other**	8	5	13*
Total	**73**	**29**	**102***

Second Choice of Treatment

	Med.	Drug	Home	Healer	Total
Medical	2	--	1	--	3
Drugstore Remedy	2	--	--	4	6
Home Remedy	2	2	--	--	4
Healer	--	--	1	--	1
Other**	--	1	--	--	1
Total	6	3	2	4	15

Outcomes of Second Choice of Treatment

	Cured	Not Cured	Total
Medical	3	2	5
Drugstore Remedy	2	1	3
Home Remedy	--	2	2
Healer	2	2	4
Other**	1	--	1
Total	**8**	**7**	**15**

n = 105 Health Problems
* Three cases missing among the cross-tabulated problems
** Other includes no treatment, massage, prayer

The section outcomes of treatment of Table 4 shows the most popular first choice of treatment was drugstore, and slightly more than half began with the more scientific medical or drugstore treatment. Of the 102 problems treated, 73 were reported cured. In Table 4, "Second Choice of Treatment" shows 15 choices made by persons who sought a second treatment when the first attempt failed (14 did nothing more or did not report). Of these, six went to the doctor on the second try, and five of the six who had first tried nonscientific remedies chose medical or drugs for the second treatment. "Outcomes of Second Choice of Treatment" shows that while more than half were cured, scientific and nonscientific treatments were about equally effective.

We asked respondents if they or anyone in their household had been ill from Susto, Mollera, Empacho, or Mal de Ojo and how they treated those conditions. We found differences among those born in the U.S. and in Mexico in identification of these folk diseases, as shown in Table 5.

Table 5

Folk Disease by Birthplace

	Susto		Mollera		Emphacho		Mal de Ojo	
	USA	MEX	USA	MEX	USA	MEX	USA	MEX
Yes	10	25	3	13	10	23	16	25
Don't know	2	2	6	4	4	4	7	2
No	18	20	25	30	17	21	9	23
What's that?	4	3	--	3	2	2	2	1
Other	--	--	--	--	1	--	1	--

n = 88 Interviewed farmworkers. Four respondents did not answer

Health Education. Of the 43 respondents who used health care services in west central Illinois, 25 of them were exposed to some type of verbal or written form of health education. The remaining 18 did not receive health education; these were females between 21-68 years old, monolingual, and with less than six years of education.

Sixty-six respondents answered that they would like to attend health education classes if they were offered. Among the topics in which they expressed interest were, in order of preference: first aid, nutrition, and disease prevention.

Discussion

The data supported the general notions of our literature review that migration transiency, poverty, lack of education, and language limit health service access for MMFW. On the other hand, the health of this group was much better than expected. This may be explained by the fact that this particular group migrates only five months each year.

Four of those months are spent in Washington state, where the group has access to a migrant health clinic. When they are in Texas, they have access to both the United States' and Mexico's health care systems. Their local problems were mostly due to their short-term status, lack of communication, unfamiliarity with community health care services, and scheduling problems.

Efforts could be made to overcome those problems. Some strategies that may be used include providing translators, creating a guide to community health care services and physician's offices, keeping physician office hours in the late afternoon and early evening during the summer migrant season, or using nurse practitioners or physician assistants to meet the medical care needs of these workers. Such strategies may increase Mexican migrant farmworkers' access to physicians' offices and could decrease the use of emergency rooms, and consequently decrease the cost of the health care for migrant workers and the community.

With regard to the controversy about the interaction of folk and scientific belief, these findings support the literature indicating little or no interference was found (Commission on Civil Rights, 1978; Higginbotham, Trevino & Ray, 1990; Madsen, 1964; O'Brien, 1983). However, it may be helpful if health providers were aware of these beliefs. Such knowledge may help the health provider to establish rapport, provide more sensitive health care, and avoid being the source of "Evil Eye."

Many traditional beliefs are not completely incompatible with modern medical beliefs, however, awareness of differences in names or explanations of common illnesses can be useful in providing health services to this population. For example, much of MMFW resistance to medication could be overcome by accommodating to their concepts of "hot" and "cold" diseases. Similarly, their fears of a practitioner's "Mal de Ojo" may be removed by affectionate touching.

Implications for Health Education

Advantage could be taken of the fact that the Mexican migrant farmworkers expressed interest in receiving health education. Coordinated health education programs in first aid, nutrition, disease prevention, and prevention of job related injuries can be implemented despite their short stay in each work location. Most MMFW follow the same route

year after year; therefore, the communities involved could coordinate health education efforts to provide optimal health education opportunities. Although only 35 percent of the health problems experienced by the MMFW were treated by self-prescribed, over-the-counter medication (such as injectable penicillin), future health education may focus attention on this important subject.

Health care practitioners and health educators in areas where MMFW work need to be alert to the differences in cultural beliefs not only among Mexican migrant farm workers but also other groups who may have different cultural backgrounds. Health education can be a powerful tool when used appropriately, but it cannot be used appropriately if clients' beliefs and traditions are not first understood by providers.

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