Women's Health Issues in the Migrant Farmworker Community

Introduction

This paper will give an overview of the conditions of migrant farmworkers in the United States, with special attention to women's health issues and how they are related to the unique circumstances of the migrant farmworker community. I base my observations on my own work experience as coordinator of a program for farmworkers with disabilities at the Center for Human Services in Gettysburg, Pennsylvania[i], as well as my field and bibliographical research on the topic.

A lesson learned by all of us who work in programs serving migrant farmworkers is that we must accept the fluidity of their migratory state, and the effects of migration on many aspects of their lives. The same imbalance that farmworkers experience as a consequence of migration also influences the work that we do and how we do it. An example of this shifting of circumstances is the lack of accurate information about many important aspects: how many farmworkers are there in the United States? What are their health records, and how do we keep track of them as they move from one state to the next? How do we recruit them to our services if they change addresses and telephone numbers so frequently? How can we plan for the future if we lack the necessary information to project, for example, what the composition of our staff should be? Currently, at the Center for Human Services in Gettysburg, most of the staff is Spanish speaking because most of our clients are Mexican. Migratory patterns change. In the past, African-Americans, then Puerto Ricans predominated. Now Mexicans and Central and South Americans predominate, but there are also Native Americans, Creoles, Asians, and Caucasian Americans who also work in the fields (National Advisory Council on Migrant Health 1992). We might have to change the staff to accommodate to the new migrant farmworker population. There are increasing numbers of Haitians working in the fields along with the others, and if this population grows, the Center will have to employ counselors and teachers that have a knowledge of French. An even more complicated factor is that most of the Haitian farmworkers speak Creole, a language which is not as common as French. This is just one example of the complexities of serving a population that is constantly moving as well as shifting in nature. We must also keep in mind that different areas of the United States attract different ethnic groups to migrant work. Therefore, we cannot generalize about migrant farmworkers as if they were an ethnically homogenous group. I can only speak about the population in the South Central Pennsylvania area, where the majority of the migrant population is Mexican at this point in time. Adding to the already complex problem is the fact that many agencies that serve migrant farmworkers have different standards and definitions for migrant farmworkers. This lack of uniformity overall has a negative impact on the effectiveness of health services provided to this population.

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Migrant Farmworkers in the United States

The work done by migrant farmworkers is one of the most dangerous occupations in our country (Trotter 1988). Farm work is a high-risk activity, involving tasks that often endanger workers, such as work with heavy machinery, sharp tools, dangerous chemicals in fertilizers and insecticides, overexposure to the sun and to heat, and often long working hours of backbreaking work. In addition to the dangerous nature of farm work, there are the risk factors involved in a typical migrant farmworker profile.

A typical scenario for Mexican farmworkers begins at the origins. Economic necessity forces them to leave familiar surroundings and, if all goes well up to the border with the U.S., engage in a very dangerous border crossing. Any of the following may happen:

- They could cross undetected and safely make contact with a relative or guide that will help them reach their destination.
- They could be caught by the border patrol and sent back home.
- They could cross and encounter a very difficult journey to their destination, especially if they have no transportation and are unprepared for weather conditions in the U.S.

Many have died trying to reach their destinations, either before reaching the border or after. One cannot underestimate the impact of this first journey as the first of a long series of destabilizing factors that make up the migrant farmworker profile (Valiela 1999). The separation from family, community, culture, and language all add up to a state of stress and vulnerability, the degrees of which vary depending on the support the person is able to receive once in the United States. These circumstances, which are often traumatic, predispose migrant farmworkers to illness.

In addition to the stress resulting from this dramatic change in their lives, there are significant hurdles, which are common to foreign-born migrant farmworkers. It is important to realize that of the approximately 5 million farmworkers in the US, 7 out of 10 are Latinos, and half of these Latinos are Mexican. 2 out of 5 farmworkers in the US are migrants, and migrants are almost all foreign or US born Latinos (Mines, Boccalandro, and Gabbard 1992). In the Gettysburg area, where the orchards of the surrounding area demand a workforce that will ebb and flow with the demands of the growing and harvest seasons, the great majority of migrant farmworkers are Mexican. Their most common and significant hurdles are related to the following factors:

- Immigration status
- Language
- Culture
- Work
- Education
- Health

Each one of these six areas of their lives is intertwined with the others in a network of risk factors associated with their temporary and migratory existence. Together they create a reciprocal impact effect, creating a downward spiral in the quality of their lives. Just as an example, we can point to the immigration issue and its relationship to all the other factors. Many undocumented workers are migrants, willing to work when needed, on a temporary basis, and to move on to where a new harvest is to begin. Undocumented

immigrants are most likely to take on this work because they know that employers will not ask for documentation, only a social security number, without checking if it is authentic or not. This way a mutual understanding takes place between employer and employee, at the same time putting the employer at an advantage over the employee. He knows that he has hired a person who is likely to have the following profile:

- Is afraid of being sought out by the INS.
- Is unable to speak English well enough to defend him or herself.
- Is unable to understand the ins and outs of the new culture and society.
- Has limited work options.
- Has a low educational level.
- Is willing to work hard and put in long hours.

Under these circumstances, the migrant farmworker becomes an easy target for exploitation. Migrant farmworkers, be they foreign or US-born, earn the lowest incomes of any employed occupational group, with an average yearly income of $7,500, and work under the worst sanitary and housing conditions of any industry in the United States (Trotter 1988). Because many of them are undocumented, they are not likely to join unions, and rarely receive disability insurance benefits or get sick days.

As coordinator of a program for farmworkers with disabilities, the majority of my cases were people who were still working in spite of their painful conditions. Often the disabilities were caused by the work conditions, other times the fact that they continued working made their original ailment worse. They also have a problem accessing health services because they live in isolated migrant camps and lack transportation. Even if they do get to a doctor, they seldom can afford to pay for their medical care. The tendency is to turn to their own culture's home remedies (Trotter 1988). If the ailment persists, they arrange for medicine to be brought to the US from Mexico, or even go as far as to return to their country where they can have treatment more cheaply, and in an environment where they feel that they are more in control of the situation.

It is important to discuss the health issues of migrant workers in the context of their unique circumstances as poor, migratory, foreign, isolated, discriminated, and often criminalized people. We cannot talk about migrant farmworkers without talking about the paradoxical treatment of workers who are needed and invited to work in fruit and vegetable farms all over our country, while at the same time they are not given visas to come in legally (Freedberg 2000). Our immigration policy towards foreign migrant workers has a devastating effect because it leads to extreme poverty and isolation, which in turn have a direct correlation to their ill health.

The living and working conditions in the camps are the main culprits in the health risks associated with migrant farmwork. Poor nutrition and hygiene are the two most important contributing factors to their illness and disease in this country. In fact, their health conditions in this country have been described to be at Third World levels (Trotter 1988).

I have up to this point described the context in which a migrant farmworker must live and struggle to survive. The next part of my paper will relate more specifically to the unique circumstances of women in the migrant farmworker community, and how their health is affected by these circumstances.

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Migrant women have a high rate of stress and depression, which begins at their point of origin and is worsened by the trip across the border. All migrant farmworkers face some degree of stress during the journey to the US, and women are additionally vulnerable to rape and robbery. Remigia Sandoval, one of the counselors at the Center for Human Services, informed me that there is an extra danger for women in these two areas, but by the same token, they are more protected by family and friends in their journey. Those who do not have this protection are exposed to more dangers.[ii] In conversation with some of our women clients there were indications of high levels of distress over early child abuse, spousal abuse, and overall trauma resulting from a combination of factors that undermine self-esteem and destabilize the person's ability to function to her full potential. It is not easy to reach people who have experienced these levels of stress, and often they initially do not wish to talk about it. However, counselors who are effective communicators, particularly those who are part of the local Hispanic community and who have experienced migration, are able to reach those who need to discharge the accumulated stress in order to begin the healing process. It is important to include the psychological factors at the beginning of our discussion of women's health because of their impact on the physical aspects of health.

In my own interview with Cathy Hernández[iii], a registered nurse who works for our Migrant Education program in Gettysburg, I asked about the most common health issues in general and, specifically, about the health of women in the migrant farmworker population in the Gettysburg area. She listed, by number of cases, for the general population of farmworkers: dental problems, upper respiratory problems and asthma, and skin conditions. Among the older migrant farmworkers, diabetes and high blood pressure abound. She considers that the number one problem that acts as an umbrella over all of these ailments is the lack of preventative care.

According to Ms. Hernández, most of the farmworkers who come from Mexico are healthy and their health deteriorates after they have been in the United States for a while. This is mostly due to poor diet ("junk food" such as candy and sodas) and lack of medical attention. Some farmworkers do bring illnesses such as tuberculosis or various types of parasites with them. There are many skin ailments reported because of their work with pesticides and their lack of protective clothing and measures, and because there are no regulations about the use of dangerous chemicals. She suspects that these chemicals are responsible for a lot of the cancer cases, especially liver cancer. However, she also stated that not enough studies are being conducted on the effects of pesticides on the people that work with them and around them.

In her answers about women's health, she also stressed that the number one problem is lack of preventative care, particularly with regard to the high incidence of cervical cancer that goes undetected because of migrant women's poor access to medical care. There is also a high incidence of high-risk pregnancies, due in part to high levels of pregnancies in very young as well as much older women. The absence of prenatal care early in pregnancy is common, leading to a high incidence of premature births and complications in the newborn baby's health (Trotter 1988).

There is a double obstacle to overcome in the case of women's gynecological needs. On the one hand there is the inaccessibility of health care, and on the other hand

the cultural restrictions that women have internalized, and which manifest themselves in the form of an unwillingness to expose themselves to a medical doctor, particularly a male doctor. Ms. Sandoval informed me that this attitude is very extreme sometimes, almost as if it were a matter of honor. She told me about a husband who complained about the doctor seeing his wife's body and then charging him $600, when, in the husband's opinion, he should have charged the doctor for the privilege of seeing his wife. Some women are so hesitant to subject themselves to examination that they rather risk death from illness rather than have to expose themselves to a strange man. This attitude on the part of men and women points to a general attitude towards the woman's body as not her own. Instead of taking care of the well being of the woman by taking care of her body, the emphasis seems to be on other people's interests. In this case, the husband sees the wife as his property, apparently uninterested in what the doctor has to say about her health. The woman who refuses to be seen by a male doctor also prioritizes the idea that only her husband has the right to see her body, even if it means not taking care of her health needs. This self-sacrificing attitude also explains why women often neglect their own health because they consider more important other matters related to their families. This particular self-sacrificing attitude can be said to be prevalent in the Mexican population, but it is not exclusively a Mexican trait.

It is important to stress the role of home remedies that include anything from ritualistic tummy rubbings with an egg in order to get rid of a "mal de ojo" to the use of herbal teas. Herbal teas present an unusual complication because doctors are sometimes unaware that patients are taking them, and when they prescribe medications there is no communication about home remedies. Sometimes there are dangers involved, as in the case of one migrant woman who was prescribed digitalis for her heart condition, and the doctor did not know that she had been taking foxglove tea, which is a natural source for digitalis. The woman had to be hospitalized with a digitalis overdose (Trotter 1988).

A woman in the migrant farmworker community has, as caretaker of her family, a strong role to play in the treatment and healing process of the members of the family, including herself. Because of women's special interest in their families' health, there have been successful outreach programs that have trained migrant women in basic preventive health measures so that they could become "lay health advisors" on general maternal and child health issues (National Advisory Council on Migrant Health 1992). This is just one example of the efforts of many outreach programs to enlist migrant farmworkers in roles that would effectively bridge the gaps of communication between the migrant population and the often complicated world of services in US society.

Conclusion

The health issues of the migrant farmworker community are many, and they are interrelated because of the unique circumstances they share. The women and men are subject to many of the same circumstances, but women are also subject to specific vulnerabilities due to their reproductive roles, the roles assigned to them by their cultures and their internalization of attitudes that are detrimental to their health. On the other hand, women exercise a special role as caregivers, seekers of health services, and health promoters. They use the resources of their own culture, as we have seen in the use of home remedies and knowledge passed on from one generation to the next. They are also

willing to seek medical assistance, even if they have to negotiate multiple barriers such as their unfamiliarity with the language and the system of medical services. Our experience in our program shows that the simple act of using a telephone is an overwhelming obstacle for most of the migrant farmworker population. This detail alone presents a great barrier to the ability to obtain medical services. This array of barriers is constantly being faced by the women and the men of this population, and shared by the numerous programs and agencies that serve them. It is very rewarding to participate in the process of dissolving these barriers, together.

Endnotes

[i] The "Migratory Agricultural Workers and Seasonal Farmworkers with Disabilities Service Project" was funded by a grant from the Department of Education to the University Research Corporation, whose non-profit affiliate, the Center for Human Services, houses and oversees the coordination of services provided by the project's collaborating agencies.

[ii] My conversations with Remigia Sandoval took place over an extended period of time in February-March, 2000.

[iii] Interview with Cathy Hernández was conducted on 2/29/00.

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