Health Services and the Migrant

Who Are the Migratory Workers?

SO far, few machines have been invented to replace human beings in gardens and orchards at harvest time. Until more such machines are invented, the cultivation and harvest of much of America's giant farm crop will depend on the availability of migratory workers. "It still takes judgement and deft human hands to pick the perfect berry, leaving imperfect or overripe ones to be harvested later."[2]

Each spring, as crops ripen and hands are needed, nearly a million migratory workers take their belongings and their children and travel with the harvest.[1,3] Close to 500,000 of these mobile persons are under 18 years of age. Many work long hours in the fields. Children over 9 are usually considered working hands, an additional source of income to the family.[3]

"Some of these families have contracts with growers for specific work at specified localities; others are on their own, uncertain of their ultimate destination or whether they will find work, gambling against time, weather and crops." Some may travel only a few hundred miles but others have no home at all and travel 12 months a year.

> A new amendment to Title III of the Public Health Service Act may pave the way toward a solution of the migratory workers' health problems. This concrete national action to meet the need for migrant health services authorizes a maximum federal appropriation of $3,000,000 for the fiscal year ending in June 1963 and for each of the two succeeding years. Primary emphasis is placed on grants for the establishment of health clinics for migrant families.[1]

There are three cultural groups of migrants and three basic routes of migration. Southern Negroes work their way up the eastern seaboard from Florida to New York and sometimes into New England; some of them filter into the Great Lakes states. In recent years, Spanish-speaking Americans have entered this stream.[3]

Many of them are recruited by agricultural associations or large growers to work as part of a crew. Crew leaders or labor contractors usually act as middlemen, negotiating working and living arrangements for a crew. Most of them are honest, but because of the lack of regulation of this operation, the migrant is often the victim of an unscrupulous middleman.[2,3]

Another stream, largest of the three, originates in South Texas. These migrants of Mexican descent usually travel in extended family groups. The majority work as far north as the Great Lakes states and then migrate back to the cotton fields of west Texas. Some Anglo Americans from the south central states work into this stream.[3]

The third stream, including many Spanish - speaking Americans, works mainly in California, some moving as far up the west coast as Washington and Oregon.[3] American Indians frequently work in central and western states.[2]

Health and Nonresidence

Wherever migrants are, health problems may be found, problems that affect

"Article and illustrations reprinted with permission from Currents in Public Health, Vol. 3, No. 2, Ross Laboratories, Columbus, Ohio, 1963."

both the migrant and the communities that attract him.[1,2] The mobile status of migrants means that no single community or state has the sole responsibility and none alone can plan for the continuity essential for effective health services.[2] It is estimated that all states but two have areas where migrant labor is needed sometime during the year.[3]

Many times the workers migrate into counties or states where they must live months or years before they can be legal residents. As nonresidents they may be ineligible for health care, according to existing laws.[2]

Some of the communities where migrants work are isolated and thinly populated and their health services even for permanent residents are likely to be deficient.[5]

In other areas, the public has been reluctant to provide for health care of the migrant. Often, health services are instituted only after an epidemic or disaster among migrants has adversely affected permanent residents.[2]

Constructive efforts to provide health care have been successful in some areas but have little relationship to efforts being made elsewhere.[2] "One community may include [the migrant] in a local immunization program. A health record may be carried by his family to the next community. But the next place may be unprepared to follow through."[3] And often, the migrant's ignorance about health services and their purpose prevents him from utilizing those that are available to him.[2,4]

In fact, the migrant does not have the protection provided to noncitizen migrants who come each year from Mexico and the British West Indies to work the crops. "Contracts for the extraterritorial workers provide some health insurance, workmen's compensation, minimum standards in transportation and housing, and work guarantees."[2] These nationals have to return to their countries when the contracted term ends, but they do have health protection

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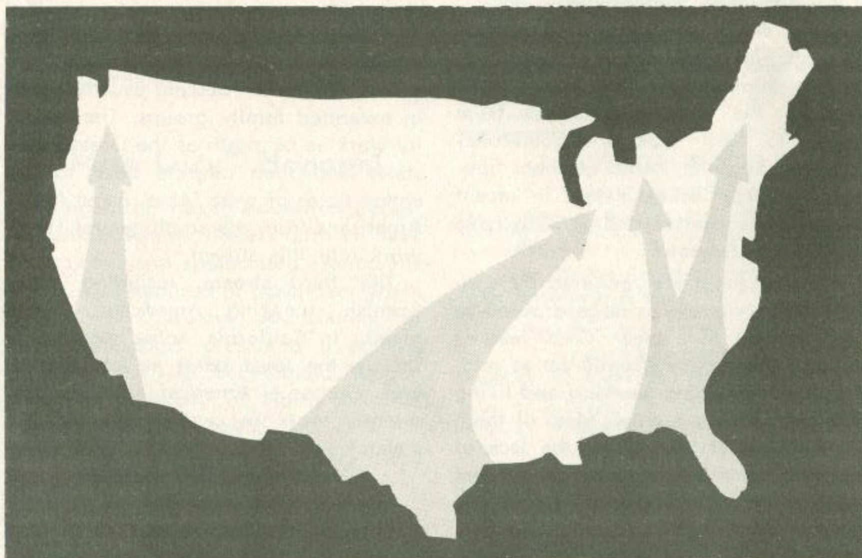


Seasonal progress of the four major migrant labor streams during the year.

Migratory Workers in North Carolina

According to the Employment Security Commission, the total number of migrant laborers used in North Carolina in 1962 was 12,153. This included 1,988 migrant workers who are residents of North Carolina.

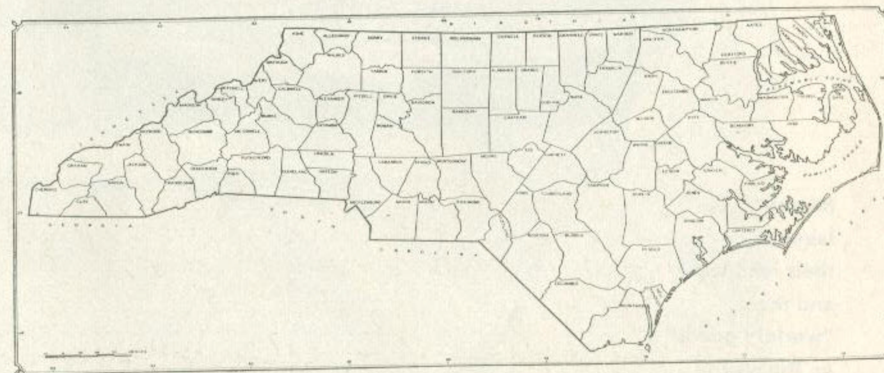
They were distributed throughout the migrant belt in various areas. These areas are: Albemarle Section, which would include Currituck, Camden, Pasquotank, etc.; Washington area, which would include Pamlico, Martin, and Beaufort area; the Wilmington area, the Mount Olive area, the Winston-Salem area and the Hendersonville area.

The kind of crops harvested consisted of Irish potatoes, sweet potatoes, beans, corn, cucumbers, watermelons, tobacco, blueberries, mixed vegetables, and apples.

The legal responsibility with regard to housing and sanitation of camps, where there is such legal responsibility, is in the hands of the local health departments. Some have adopted local ordinances. The enforcement of these local ordinances has been very lax in most instances.

The only State Law we have, which is enforced primarily by the local health departments, is the one relating to safe disposal of human wastes. We have spent considerable time in recent years working with the employers of migrant labor, particularly those having housing facilities, to provide protected water supplies, safe sewage disposal, garbage control, and minimum housing facilities. The local health departments have cooperated with us and some progress has been made. The standards, under which we have been operating, have been minimum standards applied on a voluntary basis.

The needs include the provision of legal authority to establish State-wide standards in order that facilities would be provided at all places where migrants are housed and would provide a base on which we could conduct our program. The absence of any State-wide standards makes it difficult to develop an effective program and secure reasonable enforcement and results.



Migrants on the Road

Migrant laborers, their families and their "worldly goods" on the way to the next job harvesting the crops.

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while here to an extent unheard of for the average migratory worker citizen.[2]

Problems Related to Health

Cultural difference—For the migrant, problems of nonmembership in a community are compounded by his position in the lowest socioeconomic level and, usually, in a minority group. He may be Negro, Indian, Anglo, Texas native of Mexican extraction, Oriental, Filipino or Puerto Rican. "The wide gap that exists between these cultures and those in most American communities makes outsiders of the migrant worker and child, with few exceptions."[2]

Education—Experience has shown that an effective way of altering family health practices is through educating the children. "But the education of the migrant worker's child is impeded by his migrancy and his isolation in camps far from schools, libraries, clinics, hospitals, and other community services."[2] His education may also be impeded by his working in the fields with his parents, if not during school hours, often after school hours. Unpublished Bureau of Labor Standards tabulations showed that in July, 1957 an estimated 457,000 children 10 to 15 years old—many migrants—did paid agricultural work.[3]

The average migrant obtains no more than a fifth grade education.[5] When school attendance is so often interrupted, children must adjust to new texts, methods of teaching and classroom situation in each school entered. "Studies in Oregon, Colorado, California and other states indicate the consequence—the majority of migrant children are behind their proper grade level for their age by the time they are 10 years old. When they reach their teens, their over-size in comparison with other pupils of the same grade is embarrassing and school attendance becomes a painful experience to be avoided as quickly as the legal age for leaving school is reached."[6]

Income and Housing—Migrants suffer from "the insecurity that goes along with unpredictable and unusually low incomes. The average migrant worker earned $859 in 1957."[3,7] Average family earnings were probably less than $1,800.[8]

Families usually live near the work site in over-crowded, poorly constructed housing facilities. Toilet facilities often provide for neither decency nor essential sanitation. "Whole families frequently live, cook, and sleep in one room. Such housing can rob everyone in the family of self-respect."[3]

Status in community—Migrants soon become familiar with the signs, "Migrants Not Admitted," often found in windows of restaurants, shops and theaters. Forbidden to play in community playgrounds or to swim in community pools, children and teen-agers are chief victims of loneliness and lack of community roots. Deprived in this manner of any sense of belonging and prevented fro mparticipating in community affairs during his short stay, it is no wonder the migrant neither expects nor attempts to utilize such health services as may be available to him.[2,3]

Health of Migrant Families

Public health and crippled children's clinics may be open to the migrant, but he may be unaware of them or shy about requesting health assistance. Or clinics may be echeduled at times and places inaccessible to a family with no transportation available and a pressing need for both parents to work long hours each day to earn as much as possible during short crop seasons. "The purchase of medical care may cause the family severe deprivation, since the community public welfare resources to assist low income residents are not generally available to transients, including members of migrant families."[3]

Migrants generally "share the health problems of other families handicapped by poverty, minority group status, lack of knowledge, and peographic or social isolation. Poor nutrition, diarrheal disease, impetigo, respiratory infections, and other ailments are often reported. A study of migrant health in a western state in 1950 found that the infant mortality rate among migrants was nearly twice that for the state, and that more than a third of the births in a five year period were not attended by a physician. . . . The mental health hazards of migrant living are usually unrecognized."[3] But diarrheal and nutritional diseases are the natural outcomes of poor sanitation and living conditions. Poor diets are the natural result of low purchasing power, lack of adequate food, poor cooking and storage facilities and lack of understanding of nutritional requirements.[5] Alcoholism and occasional outbreaks of violence in camps may be looked upon as reflecting low moral standards or lawlessness. But they may indicate, instead, emotional problems related to the tensions of migrant living.[3]

What the migrant believes—Because migrants often differ from other residents in attitudes and customs and because there may be a language barrier, the efforts of local health workers may founder on misunderstanding.[3]

For example, in one state, it was found that Spanish translations of standard teaching materials were of little value to Mexican migrants from Texas. Education about the basic seven food groups meant little to women who worked in fields from dawn to dark. They needed help, but from health workers who understood that they had little money, little time, no refrigeration and the most meager cooking equipment.[4]

Better methods of measuring the medical needs of migrant children are needed as well as methods of evaluating the steps in improving their health status. "The need for coupling social with medical research is fairly obvious. . . . Domestic farm migrants in some respects present medical problems of 50 years ago," Johnston states.[5]

It has been found that the migrants' concepts of immunization are often vague and erroneous. One group of health workers found that "diarrhea, intestinal parasites, and copious nasal discharges were so common among them [migrants] that they considered such conditions normal. They had little insight into a continuing need for x-ray follow-up and medication in tuberculosis; flies and mosquitoes were pests, not acrriers of disease. It is obvious that health workers will be frustrated in their attempts to change health care practices of these people, before they have an accurate knowledge of their concepts on health and disease, and of course of the ones that may be altered for their benefit." Experience has shown the need for flexibility and adaptability in the health workers who serve migrants.[4]

What Some Agencies Have Done

Florida project — The health center staff in Belle Glade, Palm Beach County, saw about 6000 migrants during a recent two-year period.[9] A team approach to health problems of the migrants is used. A liaison worker, a member of the Negro community known to the migrants, "transmits health information to migrants in their cultural terms, and aids the staff in the interpretation of their reactions. The invaluable contribution of this worker suggests that selected leaders among migrant groups could be developed as intermediary persons who would be most effective in securing changes in health care practices among their people.[4,9]

As a direct result of this program,

many generalizations formerly held by health workers about health care for migrants were changed. It was found that the migrant tended to neglect health problems because he was unfamiliar with local resources and because he did not fully understand their purpose. But when known principles of health education were adapted to him in terms he understood, his attitudes began to change.

Maternity care — Expectant mothers attended a prenatal clinic conducted by public health nurses. After laboratory tests were performed and patients were counselled, the migrant women were offered prenatal care in a doctor's office and hospital delivery at a reduced fee. Special arrangements were also made to permt them to stay in hospitals for two days at reduced rates. Some appeared to appreciate private care; they later went to a private physican and paid the regular fee instead of returning to the clinic. When advice was offered in familiar terms, they began to learn to budget their very limited incomes.[9,10]

Well-baby conferences were conducted at traditional once-weekly immunization clinics. "Services in addition to immunization included weighing and measuring the children and inspecting them for gross defects. Nursing conferences regarding formula preparation and the addition of solid foods were held with mothers who brought children under one year of age."[10]

Many diseases were found among supposedly well families, including hypertension, brain or abdominal tumors, uterine cancer, cardiac abnormalities, anemias, diabetes and nutritional deficiency diseases. "Gross dental decay was seen in about 95 percent of adults and 75 percent of children. General status of health in the children was better than would be expected in such a group. The pediatrician attributed this to high fetal loss, high infant death rates, and deaths in young children that might have been prevented by medical care. Apparently children in this well-family clinic had managed to become part of the 'survival of the fittest' group."[4,9]

Invitations to the clinics became status symbols among the Florida project group. Families heard about the clinics and began requesting appointments.[10]

California clinics — Migrants working on Fresno County's isolated cotton ranches obtain health care at the Westside Clinics.[4,6] The clinics open after the day's work is done and they do not close until the last patient is seen—sometimes as late as 2:30 a.m. They are staffed by volunteer physicians, resident physicians from the county hospital, public health nurses and citizen members of the Fresno County Rural Health and Education committee.

After this community group opened the clinics, a dramatic decline in the infant mortality rate and a noticeable decrease in the number of county hospital bed patients from this group were seen. The clinics are part of the county health services.

During the first three months they were open, only 85 migrants sought medical services. "Eight years later, in 1959, 1,333 came in those same three months and a total of 600 clinic visits were made that year. Of 330 mothers given prenatal care, 214 visited the clinic before the sixth month of pregnancy. An average of 1200 to 1400 children in Fresno county are seen at the 20 child health conferences held each month. Parents receive education in preventive medicine and accident prevention is stressed. Immunizations are given, and children who are ill are referred to their private physicians, county hospitals, Westside clinics or other indicated children's services."[4]

Although there has been a significant

increase in the county's child population since the clinics opened, infant mortality has decreased about 22%. The number of diarrheal deaths has dropped. Among children there has been a general decline in all reportable diseases except tuberculosis. Staff members have noted a change in the types of families seen at the clinics; they seem to migrate less. Better standards of hygiene and living are seen in home visits.[4,6]

Implications—The existence of these health services shows that a coordinated, community effort offers one practical approach to improved health education and care for mobile or isolated groups.[4]

Henderson suggests[11] that a central directory be formulated to list available services on a nationwide basis. This might facilitate referrals for the migrant workers seen by health agencies. Attempts have been made to design health records that migrants could carry with them. Crew leaders have been helpful in persuading workers to carry these, but with limited success. As a rule, the migrant won't carry anything larger than a wallet-sized card.[4]

The Road Ahead

Jessup states, "It seems to me that our greatest hope for the solution of the problems of migrant families in the future lies in the growing recognition of the need for interagency and interstate planning. We in the state and the local public health agencies are deeply interested and want to do our part, but we have no way as individual agencies to assure continuity of the basic services that migrant families need wherever they live temporarily, nor as health agencies have we the mechanism of the employment service for scheduling workers and for predicting the number and characteristics of the migrant population for which plans need to be made at particular places and particular times. Many aspects of our state and local health task rely on the efforts of other states and localities and other groups, including the employment service, the employers, and the migrant families themselves."[6]

The coordination needed between agencies may ultimately result from the stablishment of projects under the new legislation. The 1962 migrant health bill authorized[1] two mechanisms "through which a solution to the migrant health problem can be approached:

1. By granting funds through the Public Health Service to pay part of the costs of projects submitted by public or other nonprofit agencies.

2. By expanding technical assistance of the Public Health Service, placing emphasis on encouragement and cooperation in intrastate or interstate programs to improve health services or otherwise improve migrant's health conditions."

Primary emphasis will be placed on family health service clinics. Grants will cover part of the cost of estabilshing and operating these clinics and of consultation from the Public Health Service. Field staff will help states, local communities, and private nonprofit organizations coordinate migrants' health services. No specifc State or local cash matching is required, but the amount expended by States, communities, and nonprofit organizations is expected to exceed the Federal grants. Responsibility for planning and conducting programs will remain with States and local communities.[1]

It is inevitable that migrants will continue to have health problems and that their problems will continue to constitute problems for the communities and states where they temporarily reside. The new Federal legislation may put an end to the problems that arise because of the migrant's inability to

meet local and state residence requirements. But the integration of health activities on an interstate level will not be easy to achieve. "Only to the extent that the dynamics of the migrant's life are recognized and understood" can health personnel begin to meet the health needs of those in our population who "follow the sun."[12]

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Shephen Mason Thomas of Sylva, N. C. was one of the winners of a 1963 Morehead Scholarship. Stephen is the son of Mr. and Mrs. C. B. Thomas of Sylva. "Charlie," as he is known to his many associates in public health, is Sanitarian Supervisor with the Jackson-Macon-Swain District Health Department.

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