# HEALTH CARE FOR MIGRANT FAMILIES

Resource ID 8067

Health Care for Migrant Families

When Mrs. Michigan Housewife goes to the supermarket and buys the high quality Michigan-grown fruits and vegetables which she has come to expect, it's doubtful that she is aware of, or appreciates the fact that she and her family are benefiting from the sweat and toil of migrant agricultural laborers.

But whether or not she realizes it, the availability of quality produce at reasonable prices depends to a great extent on the thousands of migrant workers who come to Michigan annually to work in the fields and orchards. For example, berries, peaches, cherries, tomatoes, cucumbers, and other fruits and vegetables must be harvested within a short period before they become over-ripe. Were it not for the presence of cheap migrant laborers, only a small amount of these crops could be placed on the market, with the prices soaring out of reach of the average consumer.

Much of Michigan's agricultural economy is dependent upon migratory workers. Of the state's total farm labor force, 58 percent are migrants involved in the planting, cultivating, or harvesting of crops valued at approximately a half-billion dollars—34 percent of total farm cash receipts.

Michigan ranks third in the nation in the number of migrants employed, with about 90,000 working in the state during peak periods—primarily in the fruit belt along the western side of the state, and the sugar beet, tomato, and cucumber growing areas in the thumb and southeastern part of the state.

Housed in some 7,000 work camps, the migrant's average yearly income is about $855, with total family earnings probably averaging less than $1,800.

In any such sizeable group of nomadic people with low incomes and little formal education, health problems would be expected to be numerous. They are.

Migrant families generally share the health problems of other families handicapped by poverty, migratory group status, lack of knowledge, and geographic or social isolation. These problems include poor nutrition, diarrheal diseases, skin infections, respiratory infections, and other diseases. The infant mortality rate among migrant families is twice as high as that of resident populations. Physicians are in attendance at only about two-thirds of births to migrant women, and prenatal care is practically non-existent.

Diarrheal and nutritional deficiencies are a natural outcome of poor sanitation and living conditions, and poor diets, which are the result of low purchasing power, lack of adequate food, poor cooking and storage facilities, and lack of understanding of nutritional requirements.

Surveys have shown that 77 percent of migrants interviewed had never been seen by a dentist, and that 65 percent had never received regular medical care.

Only about a third of the state's migrant camps are currently inspected, and less than half of these comply with suggested minimum sanitation standards.

Thus, there is a pressing need for adequate sanitation inspection programs, maternity care, dental care, immunizations, screening programs for carriers of intestinal disease organisms, control programs for tuberculosis and venereal disease, and emergency medical care.

For many years, health problems of migrant workers were much like the weather: everybody talked about them, but nobody did anything about them.

Today that situation is gradually changing under the impetus of the Migrant Health Act passed by Congress in 1962. Steps are now being taken by many different groups toward protecting and improving the health of the migrant and his family, who contribute far more to Michigan's economy than they receive.

Through a project grant from the U. S. Public Health Service under the provisions of the Migrant Health Act, the Michigan Department of Health employed a migrant health consultant last year to provide liaison with all agencies involved, both voluntary and official; and to stimulate and improve the full use of community health facilities by migrants working in Michigan.

The core of these facilities is made up of local health departments which serve 71 of the 83 counties in the state. Each of these is potentially capable of providing a wide range of health services to migrant workers. However, most of them have difficulty in extending services to the migrants because of understaffing and lack of funds to expand programs, even though they recognize the need and are concerned about it.

To help these departments and other local community agencies provide services for the migrants, project grants are available through the Michigan Department of Health.

Last year, with the assistance of the migrant health consultant, five applications for migrant health projects were submitted to the U. S. Public Health Service. So far, three of these have been approved: a statewide migrant housing project conducted by Michigan State University's Agricultural Engineering Department and the improvement of nursing, sanitation, and clinic services provided by the Ottawa and Monroe County Health Departments.

The two community projects were established with the cooperation and support of local church groups, growers, medical and dental societies, other official county agencies, and others interested in the welfare of the migrant worker and his family.

The three-year Migrant Health Act comes up for renewal this summer. If additional funds are voted (and there is every reason to believe so) it is anticipated that Michigan will qualify for grants to support eight additional community programs.