Health Needs of Seasonal Farmworkers and Their Families

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THE past 10 or even 20 years have brought few improvements in the lives of migrant farmworkers and their families. A Public Health Service report of 20 years ago and a 1960 report from California describe the same lack of health care for nearly a million U.S. citizens. In 1940, the situation was summarized in these words. "The effect of transients on community health is to increase the hazard of ill health to residents and to raise the incidence of most of the communicable diseases. This results chiefly from the fact that transients are not given equal consideration in community programs of sanitation, preventive medicine, and isolation of infectious cases of communicable disease" (*1*).

Eleven years later a Colorado physician remarked: "We know that communicable diseases are present among the migrants. The fatalistic acceptance of the situation, plus their poverty, makes the problem of medical care a critical one" (*2*). And a Florida observer commented: "Many of the older ones just accept sickness as part of life, just as they do being out of work or living in a shack" (*3*). The California reports in 1960 summed it up as "the almost complete nonavailability of medical care and the inadequacy of preventive services available to this group of workers" (*4*).

Another California study indicated that about one out of five adults among itinerant farm laborers included in a recent study by the State vocational rehabilitation service had some kind of disability (*5*). Half of these disabled adults suffered seriously reduced earning capacity. The report concludes: "Due to their standard of living, they are . . . apt to have serious unresolved health problems and major disability."

Housing

In many areas, the usual living and working conditions of seasonal farmworker families contribute to disease and disability. Some families live in large, well-built, well-maintained, and well-managed farm labor camps with good toilets, adequate water supply, and regular garbage and trash collection. Others live in rows of makeshift units where there is little regard for human health, safety, or decency. Ditchwater is used for drinking and washing, filthy privies for human waste, and the camp and its surroundings for dumping garbage. Heating and cooking equipment improvised from discarded oil drums or other makeshift materials constitute both a fire and an accident hazard.

In the unincorporated communities and fringe areas of towns where some of these families own or rent their own housing, conditions are often as bad as in the worst camps.

Young children brought to local clinics show the results in severe burns, diarrhea, impetigo,

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and respiratory infections. There is no effective way to quarantine the results of poor housing within the particular area where the housing exists. When families move, the consequences of a bad situation may go with them, and filth-borne diseases may be spread to others even though all presently live in a good camp.

As they travel for long distances, the families need overnight shelter and places to use as rest stops. In many parts of the country, this need is completely overlooked. No stops may be made for journeys of several hundreds of miles because the driver is told to move on wherever he attempts to park his bus or truck. As a result, the families must use the side of the road between towns for infrequent rest stops.

Field Sanitation

Large-scale agriculture of the type that employs migrant farmworkers is a notable exception to the rule requiring the maintenance of sanitation standards at work locations. In other businesses and industry, we do not tolerate a complete lack of toilets, drinking water, or handwashing facilities where people are employed all day. This is still the widely accepted practice in commercial agriculture.

Testimony offered early in 1960 at the Cobey Committee hearings in California indicates that although slight risk to the health of consumers results from the lack of field facilities, a sound field sanitation program would have definite psychological benefits to consumers and sociological benefits to the workers. It seems likely to be only a matter of time until consumers will insist upon good sanitation practices being followed in fields and orchards. Their esthetic sense, if nothing more, will be offended beyond the point of tolerance as they become increasingly aware of the conditions under which some of their food is picked.

The workers themselves also object to the lack of field sanitation facilities. One picker told a representative of the California Council of Churches: "There were no restrooms in the fields where we worked last season. We went down the row far away where there was nobody working and nobody could see us. The women do not like to work in the fields because of this."

Both the housing and the field sanitation situations introduce conflict into migrant health programs. On the one hand, we health workers may try diligently to care for patients with diarrhea when they come to our attention, but we are treating only a symptom if we neglect the poor sanitary conditions which are the underlying cause. From time to time we also try to teach the workers how to maintain their own health. But what good is it to teach a worker about safe water if his only supply is obviously unsafe? And of how much value is education about good personal health practices if the only toilet is between rows of field crops or a filthy privy?

Occupational Health

Control of occupational hazards is notably lacking in commercial agriculture. In still another respect, this type of enterprise has a strange immunity. Children under 15, working or not, are seldom seen in a large factory. Yet children under 15, some of them workers, suffer each year from disabling accidents in industrial agriculture. Sometimes the mangled hands or arms suffered by young children who get caught in harvesting machinery have alerted a community to the larger migrant health problem (*6*, *7*).

Occupational risks arise not only from machines, ladders, and other farm equipment but also from agricultural poisons. Sometimes crops are sprayed while workers are in the fields, or without regard for the proximity of workers' housing. Pickers sent into the fields too soon after spraying may also suffer from poisoning. Cases of parathion poisoning affecting 70 crop workers were reported in the *Journal of the American Medical Association* (*8*). Last summer a 2½-year-old boy died in a labor camp in Illinois, apparently because he drank from a jar that still contained a little of the milky liquid used to spray cabbages.

Transportation to and from the labor camp or nearby town to the worksite, as well as long-distance transportation, is still another hazard of agricultural work. Such transportation may be by rattletrap bus or other makeshift vehicle.

On the east coast, discarded school buses, some of them decked in bright new coats of paint, are replacing many of the trucks that

were used to haul workers to and from the fields as well as from State to State. Some crewleaders are making an honest effort to meet the recent regulations of the Interstate Commerce Commission (*9*). In many places, however, there is no regulation to govern short hauls of farmworkers.

Health Services

In a study of a group of Spanish-speaking migrants, sponsored by Texas, Michigan, and the Public Health Service, few if any had previously had contact with a public health agency (*10*).

Our experience in Texas and Michigan showed that there can be no assurance that a service started in one location will be completed in another, even when a migrant follows instructions. One family, for example, had their first immunization shots without charge in a local health department clinic in Texas. The mother went to the local health department in the north, as she had been instructed, but was referred to a private physician since the health department did not give inoculations. The physician charged a fee for each of the children for the second shots. The mother did not return for the third. This is hardly surprising in view of the typically uncertain income of such families and their lack of conviction of the value of such preventive services as vaccination.

Followup may be difficult even when a community makes an effort. The results of chest X-rays, for example, often become available after migrant families have moved to a new location. Local health workers in the new area may find that the information forwarded to them about the time the family will arrive or the place where they will work is incomplete or inaccurate. Even if the sick person is found, it may be hard to persuade him to go to a hospital. He may have a strong compulsion to work while work is available so that his family will have something to live on for the rest of the year. Moreover, his fear of disease may be far less than his fear of an "Anglo" hospital where rules bar him from seeing his family and friends.

Fear and lack of understanding or acceptance of our health ways are factors that must be considered in trying to adapt the usual community health services to the special circumstances of seasonal farmworkers and their families. These reasons, rather than neglect, may explain why few of these families have had immunizations and why cases of illness they bring to a physician or clinic may be far advanced. In the Texas-Michigan project the use of folk remedies for treatment of a young infant delayed the family's taking her to a hospital for about a week. The baby died on the same day she was finally taken to a hospital.

Some conventional health methods make little sense when looked at from the migrant family's point of view. Special clinics, for example, held at different times and places for different purposes are time consuming, costly if a family must arrange and pay for transportation, and result in loss of income if time must be taken from work, since a migrant paid on a piece rate or hourly basis earns only while he works.

Our earlier example of the mother whose children needed to complete their immunization series is another case in point. The conditions under which the first shots were obtained were quite different from those in another location. Generally we expect the migrant to make all the adjustments as he seeks needed health care in one work area after another.

Current Migrant Health Activities

The West Side clinics in Fresno County, Calif., have circumvented some of these problems by the excellent cooperative relationships maintained over the years among the medical society, county hospital, health department, local growers, welfare department, and other groups. The clinics have been possible because of the grant from the Rosenberg Foundation that helped get them started and the continuing interest and wholehearted support of many local citizens.

At first, it wasn't easy to encourage the families in Fresno County to take advantage of clinic services. There were more staff than patients at a few of the early clinic sessions, and the first patient at an early maternity clinic was a man. The clinic staffs gradually learned, through experience, that papa and his needs had to be considered, as well as mama

and the children, if Spanish-speaking migrant families were to use the health services offered. Furthermore, clinics had to be scheduled in the evening so that people wouldn't lose time from work.

Now the Fresno County clinics are proud that mothers come for prenatal care before the sixth month of pregnancy. Before the clinics started, some mothers would have gone without medical care even at the time of delivery. The clinics have also turned out to be a good device for tuberculosis and venereal disease casefinding, in part because the relationship between the families and the physicians and nurses encourages visits to the clinic for care when symptoms first appear rather than after an emergency develops. The frequent friendly contact of the county health department's nurses with families in the labor camps is still another important factor in the Fresno County operation and may be one of the keys to the success of the West Side clinics.

There are few demonstrations such as that in Fresno County elsewhere in the Nation. Health services for migrant families are usually sporadic, unplanned, and unorganized within as well as between communities.

If the million-plus migrants, including domestic workers and their families and foreign workers, were all settled in one place, they would be surrounded by an organized network of services to protect and maintain health. Instead, the people are scattered and groups of varying size and composition travel to widely separated counties of the same State or different States to work each year. Each new community that becomes their temporary home has its own unique network of services, adapted to the needs and convenience of its own permanent residents. Usually built into this network are restrictions that limit the services available to outsiders.

Local and State Action

To improve the health of migrants, many different types of action might be taken. The improvement of housing seems a good place for most communities and States to start, since this would automatically relieve some other problems. A start on several fronts could logically be made.

1. Educate the community, including growers and migrant families, as to the basic requirements for providing and maintaining safe, healthful housing. This would be a first step toward developing understanding and relationships that would support good housing and crowd out bad. At present the grower who provides good housing receives no sure reward, and the one who neglects his workers' housing suffers no sure penalty. Even where housing codes set standards, inspections may be infrequent and cursory.
2. Determine the elements of motivation, planning, and management that make it financially possible, and perhaps profitable, for some employers to provide good housing in the same area where others provide rudimentary shelter.
3. Develop simple construction plans and mass-production techniques, if they do not exist, to reduce the cost of acceptable housing.
4. Develop methods of financing housing adapted to (*a*) the migrant himself if a permanent farm-labor-supply pool is needed in a particular area; (*b*) growers and their associations; or (*c*) the community, if a public authority of some type would be the appropriate agency to provide, maintain, and manage housing.

Another greatly needed step is for large-scale agriculture to accept more of the responsibilities long ago assumed by large-scale industry. California has taken a step in this direction by its extension of workmen's compensation coverage to agricultural employment. In field sanitation, control of work hazards, and other matters pertinent to the health and well-being of workers and families, growers generally have a long way to go.

Agriculture differs from other industry in some important respects. Nevertheless, this difference does not justify a do-nothing policy.

In the provision of health services, a California physician warns that a "major roadblock to solving the health problems of seasonal farmworkers is the ease with which we can, if we let ourselves, pass the problem on to someone else, and not tackle it as it must be tackled—as a community health problem" (*11*). Certainly, the community where a person lives at a particular time is the place where he can best receive the health care he needs. Moreover, the com-

A crew of migrant workers gathers for music

munity where a migrant makes an economic contribution owes him some assurance of service on a par with that received by other local citizens while he works in the area.

National Responsibility

Although emphasizing local and State responsibility is appropriate, the periodic shifting of workers and families from one community to another implies the added need for national leadership and assumption of responsibility. The separate action of single communities and States is likely to result in the duplication of some services to migrant families and gaps in others. Interstate planning and exchange, across the continent if necessary, can be facilitated by active national leadership and participation.

Recent Public Health Service efforts devoted solely to migrant workers have consisted of limited consultation and technical assistance, chiefly what three people in the Division of Community Health Practice could do on a part-time basis. Other programs have included migrant health within their scope, but this has not been their major focus. Some of us feel that our past effort has been grossly inadequate in view of the fact that the migrant health situation represents an indefensible gap in the application of knowledge we have long ago applied to the general population.

We in the Public Health Service also feel quite strongly that waiting for the problem to disappear is no way to deal with it. The Service report of 20 years ago and the California report of 1960 bear out this contention. The problem recurs with the same regularity as the crop seasons. Mechanization and other changes in farming and employment practices have radically changed some local situations. They have not affected the national situation materially in recent years. The fluctuations in local and

State situations seem to us, however, to add to the necessity for national leadership in order to keep what is done adjusted to current needs.

Some have felt that the number of persons in the farm migrant population as compared, for example, with those affected by chronic diseases and automobile accidents make their health needs negligible for consideration at the national level. We do not share this view. Instead we look at the situation as evidence of about a half-century lag in the application of existing knowledge to a sizable population, one as large as the 1960 census shows for any one of more than a dozen States.

Moreover, the size of the migrant population is not an accurate measure of the extent of the problem. Each time a person moves with his family he must have adequate shelter, safe drinking water, and safe methods of disposal of human and other waste at his new location. Each new community must also be ready to provide him with health services according to his need while he is in the local area. For these reasons, we feel that a more accurate measure of the national problem can be obtained by multiplying the population by at least the number of times the people move each season. Using two as a multiplication factor would be conservative.

In 1960 the president of the American Public Health Association submitted a proposal to the Senate Subcommittee on Migratory Labor (*12*). The Public Health Service has endorsed the principles outlined in the association statement. We agree that there is urgent need for health aid for migrants, including preventive health measures, arrangements for medical care, training for health leadership within the migrant group, and further study to determine cultural blocks and other difficulties that restrict provision and acceptance of health care.

The health needs of seasonal farmworker families are as broad as those of other families. Accordingly, the health aid available to them should encompass the range of preventive and curative services offered by communities to their permanent residents. The experience of many years has demonstrated, however, that without adaptation the usual community services often fail to reach seasonal farmworker families. To be effective in meeting their health needs, services must be geographically accessible, geared to the families' living and working situation, culturally acceptable, and planned in a way that relates the services of one area to those for the same families elsewhere.

Family health services alone, of course, are not the answer. With these must go services to safeguard living and working conditions in order to prevent needless illness and disability. With the further addition of a strong health education focus to both types of activities, the worker and his family will be helped most effectively. They will then be on the road to assuming responsibility for their own health needs in an effective way.

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