Health and Day Care for Children of Migrant Workers

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WE as a nation have been generally unwilling to assume our responsibility for the needs of great numbers of growing children whose parents work outside their own home areas. Nowhere has this been more tragically evident than in the case of children of migrant and seasonal farmworkers. Migrant mothers nearly always work in the fields. Small children are taken to the fields early in the morning, spend long hours in locked cars, and play in roadways or drainage ditches, or they may be locked in hot cabins all day with little or no supervision (*1*). As a result, thousands of our children are not only being denied the opportunity to grow up to be assets to society but are being inevitably pressed into the mold of dependency, delinquency, and degradation.

It should be remembered that children differ from adults in that they have needs peculiar to their age and immaturity. They are unable to care for themselves. Furthermore, their satisfactory growth and development depend on factors such as protection, adequate nutrition, health maintenance and restoration, and a psychologically and socially stimulating environment. Indeed the children of migrant agricultural workers represent one of the few opportunities we have to break the cyclical effects of poor health, deficient education, and lack of social acceptance in this segment of our population.

The provision of day care of any reasonable quality points up a strong interrelationship between education, social welfare, and health. Hence there is an urgent need for coordinated planning and constant communication between the three disciplines and particularly the official agencies that represent them. As is well known, health cannot be separated from family and community social situations, and education is such a vital part of any child's present and future life that his ultimate emotional and physical health are inextricably tied to it.

It will be clear to all those who have worked with seasonal agricultural workers that the problems surrounding utilization of child care programs will be great. Dr. Paul O'Rourke, medical director, and Faustina Solis, public health social work consultant, of the Farm Workers Health Service, California State Department of Public Health, have referred, in personal communication, to some of the obstacles to be overcome: lack of transportation to and from the center and the remote areas where migrant families live, dusk-to-dawn workdays, ethnic minority status of the many Negro and Mexican-American workers, peak-season influx of new families and the problems of providing adequate staff for these short periods, and the need to devise methods to overcome distrust and fear of official agencies, which often characterize the migrant agricultural worker.

Migrant families, characteristically mobile,

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will also reflect intense social isolation with patterns of strengthened family unity and interdependence of family members. It is almost as if one can equate the social isolation to the increased geographic mobility. The migrant community itself may accept quite philosophically such self-imposed isolation of newcomers. Individuals who choose not to congregate are not subjected to the usually expected resentments. Efforts to include children from migrant families in day care must vary, therefore, from those exerted by urban centers, where day care may be promoted on a rather sophisticated basis. Community interpretation, neighborhood councils, and family-to-family contact are frequently employed. It would seem imperative in the migrant community that day care programs, although developed because of local community concern, may require methods of cultivation and sustainment which involve both parents. Because of the stresses of separation, this would be particularly true when the child is enrolled. Separation anxiety on the part of the parent is often manifested through the child, and it becomes a great source of interpersonal involvement for center staff, the parents, and, of course, the child.

Another aspect is the distrust which exists toward unknown people and services. Day care services might well be interpreted by migrant families as usurping their rights and singling them out as inadequate parents. How will the father react if his children are placed under the care of total strangers? May it mean to the father that because of his inability to support the family it is necessary to "place" his child? The center must be prepared to cope with the anxiety and fear of the mother who has diligently and devotedly, within her limitations, reared her young and now must leave them in the care of strangers. Parents require help in preparing the child to use the day care experience so that he does not feel that he has been abandoned. None of these concerns can be handled through written instructions.

Great sensitivity needs to be exercised in designing a program more likely to be used than avoided. For example, the needs of the professionals may be to create a highly sophisticated, intellectually stimulating program. To many migrant families, such as the Spanish speaking, the term "education" is more basic. If one understands what emotional aspirations the parents have for the development of their children, it is possible to interweave activities which coincide with these hopes. For example, teaching the child to care for himself, to relate to other children and adults, and to discipline his instinctual drives represents concrete basic education to these families.

Strenuous, appropriate "reaching out" measures will be needed to begin an attack on these problems. Furthermore, it hardly need be mentioned that all interested local citizens and agencies should be included in the planning and operational stages. The farmworkers, the growers, the local health departments, boards of education, welfare departments, migrant ministry, county medical societies, and others must be involved as the program is planned and developed. An example of such planning in this problem area has been carried out in Kansas over the past several years (*2*, *3*). A child welfare worker has demonstrated her role in developing a similar collaborative project in North Carolina (*4*).

The program recommendations that follow will not be applicable in all situations. They require careful evaluation and interpretation by each of the concerned groups before being put into practice. In fact, a number of the suggestions may not be immediately adaptable to local facilities and personnel resources. Nevertheless, the health needs referred to will be present, and the following somewhat idealized and comprehensive program should be attempted as far as possible.

Program Content

The health component in a child care program must be integrated into the total family health plans which are being provided by local health agencies. The children of migrant families often go hungry, are undernourished, and have anemia. Diarrhea and parasitic infections are not uncommon. Eye and ear infections and the communicable diseases of childhood occur frequently. The immunization rate among these children is low. There is a higher frequency of positive reactions to the tuberculin

test, which indicates exposure to individuals with active disease. Dental disease is common. In terms of preventive as well as therapeutic services, child care centers offer opportunities, not available on an individual family basis, for coping with these health problems. The opportunities exist because the children are brought together in "captive" groups.

Health services which can be incorporated into a child care center will depend upon local needs and interests and available physical facilities and professional skills. Rather than insisting on rigid standards in these pioneering endeavors, it is essential that local programs be fashioned to fit the specific needs of the group and the community.

Staff. The health portion of the center's program will have to be supervised by a physician who has knowledge of the special health needs of children. Usually this will be the individual who is responsible for the local health department's maternal and child health services or a local physician selected by him. A public health nurse from the local health department can be designated for direct and continuing service to the operational aspects of the center's program. She can work closely and frequently, at least several times a week, with the center director. She can act as a resource person to the center director for information regarding health deviations in the children, as well as a liaison to community health agencies.

Every effort should be made to obtain a director for the day care center who knows and understands the normal health and development needs of growing children. A friendly attitude toward children and the ability to create an atmosphere of comfort and security without neglecting discipline are desirable. In most Western States it will be desirable that the director or her assistant speak Spanish. The use of Negro personnel in some situations will be advantageous. In choosing a staff important personal qualities are emotional maturity, stability, capacity for mothering, and warm interest in young children.

In some localities where seasonal farmworkers are concentrated, medical schools, schools of public health, and colleges are found nearby. These institutions represent resources for staff as well as consultation in the fields of medical care, education, child development, home economics, sociology, and psychology. One can visualize easily that cooperative undertakings could be of mutual benefit since opportunities for teaching, demonstration, community service, and research all are present. Staff volunteers could be recruited from the student bodies of the colleges. It is time we recognize that the professional individual is not the only person capable of giving good service. Specialized curriculum and training programs would develop potential personnel who could serve as an extension of the professional child care staff.

During the peak season at a child care center in Gridley, Calif., excellent use has been made of selected teenagers from farmworkers' families as assistants to trained staff. The advantages are obvious. The teenager will feel worthy; her general knowledge and skill in child care will be strengthened; and personnel will be made available for the program during the peak season. For such activity, the teenager should be paid. The use of teenagers or grandmothers from the children's families can help soften the separation anxiety.

Medical examinations. Before admission each child should have a thorough physical examination by a qualified physician, preferably a pediatrician. It is essential that the parents be present for this examination to give the child's medical history. Frequently, the child's history is more useful and revealing than the examination itself. The parents' presence also will give the physician and public health nurse an opportunity to discuss the child's health with the parents. Therefore, it often will be necessary to schedule examinations for groups of children on Sundays, in the evenings, or at other times that will assure the parents' presence. The public health nurse who has been assigned to the center, the center director and, if appropriate, the local social worker who serves these families are an essential part of this initial health appraisal. For greatest efficiency the initial medical histories may be elicited by the public health nurse with the assistance of personnel such as bilingual community health aides, the center director, and volunteers. Individual medical records in which all defects are recorded, as well as the child's height, weight, and developmental status, should be maintained for each child at the cen-

ter. If possible, examinations should be repeated for preschool children at 6-month intervals and annually for school-aged children. A personal, wallet-sized health record is available from local health departments or the Public Health Service and can be used to record all pertinent findings. This health record is designed to accompany the child and his family as they move about.

In addition to all children attending the center, it would be advisable for each staff member to have a medical examination including tuberculin testing and, when indicated, a chest X-ray.

Screening tests. Screening to detect additional health problems will supplement the medical examinations. If these tests are not done at the same time as the medical examinations, they should be done shortly thereafter.

Screening tests are available to assess vision and hearing in preschool and school-aged children. Tuberculin tests will not only detect infection or active disease in the children but can serve as casefinding devices for adult associates who have active disease. Each child needs a tuberculin test at least annually. Hemoglobin determinations can be done easily and economically. They may disclose a relatively high prevalence of anemia, which usually is nutritional in origin. Ferrous sulfate medication can be administered in the center to correct nutritional anemia. Prevention of the recurrence or occurrence of such anemia can be influenced by the center's nutrition program. Examinations of stool for ova and parasites are probably not useful since such a high proportion of this group are infected but do not have a disease. An interesting approach might be the prophylactic treatment of these children at the center with iodochlorhydrozquin (*A*), 250 mg. three times daily. This method has been successfully used by Gholz in an institution for the mentally retarded to control *Shigella* and *Entamoeba histolytica* infections (*5*).

Followup of positive findings. A physician is needed to review the results of the medical examinations and screening tests. All presumptive abnormal findings should be recorded and directed to the public health nurse who will make every effort to assure that the child receives definitive diagnosis and treatment. Hence it will be essential to arrange for medical care with a local treatment facility. If treatment is not available, the initial positive assessments will create anxiety and additional frustration for the migrant parents and be a total disservice to them.

Dental health. If the children do not have the advantage of an optimally fluoridated water supply, supplemental dietary fluoride can be provided at the center.

As a part of the initial procedure described, dental examinations should be provided at each of the centers by a local or, if necessary, a traveling dentist. A portable chair and equipment could be transported to the center and used for this purpose. Untreated rampant caries have frequently been found among school-aged children in this group. Examinations will point up the need for dental care of a therapeutic and prophylactic nature. Caries should be repaired and topical fluoride applied to enhance the effect of fluoridated water supplies.

Nutrition. The food requirements of a growing child are greater in proportion to his size than those of an adult since the child's food supply must not only provide him with energy and maintain his metabolic processes but also build new tissues. Early malnutrition in this setting will occur frequently and can be identified, and the feeding program of the center can be designed to make up for these deficiencies. Treatment with iron or vitamins is not enough. Resources such as the food distribution programs (food-stamp program, donated food program for needy families, special milk and lunch program) can be used advantageously. One or more highly nutritious meals can be served in the centers. The dietary intake of protein, vitamins, and minerals may have to be increased and, in many cases, multivitamin preparations may have to be provided, at least until deficits have been corrected. Presentation of the food and the atmosphere in which it is served and eaten also merit consideration. Mealtime can be a pleasant part of the daily program, and the staff needs to be made aware of coping with children who have eating problems. At some point parents can be instructed in proper feeding of the child, preferably through participation in food preparation for the group. Consultation on nutri-

tion can be made available to local centers in planning and developing their nutrition programs.

Immunization and infectious diseases. At the time of medical examination, the child's immunization history should be reviewed. Specific, adequate protection is essential against diphtheria, whooping cough, tetanus, poliomyelitis, smallpox, and measles. The public health nurse can ascertain the child's immunization status and, with a standing order from the medical director, can vaccinate and give injections at the center as required.

Susceptible children who are exposed to certain contagious diseases, such as hepatitis and measles, may be protected by gamma globulin if it is used early in the incubation period of these diseases. Pertussis, often a serious disease in children under 2 years of age, may be prevented or modified by the use of pertussis hyperimmune serum.

Daily inspection of children before admission to the group and the separation of those who are sick must be provided for in some way. In addition, the isolation area can be used for children who suddenly become ill, and they can be taken as soon as possible to the facility designated for treating sick children of migrant families. Volunteers may be recruited for the center who are responsible for this type of transportation and followup of medical care for the sick child. A specific method for the provision of medical care is of the utmost importance, and careful planning is needed to assure its availability. The precise facility or resource will depend on the local situation.

The local health department sanitarian can assist in planning for safe water and sewage disposal for the facility as well as improvements in general housing and ventilation. He also can interpret for the staff and children the importance of washing their hands before meals and after visits to the lavatory. Food preparation and sanitation can also be reviewed by him.

Accident prevention. One of the important considerations in providing child care for children of migrant families is the reduction in morbidity and mortality from accidents which these children have experienced in the past. Hazardous conditions, such as danger from cars and trucks on heavily traveled roads and from farm machinery and insecticides, have been reported.

There needs to be an awareness within the center of what to expect of children at different ages. During the first several years of life, emphasis is placed on the elimination of hazards. Gradually thereafter, education plays a more important role as the child is taught the risks and dangers of his surroundings. And, again, the sanitarian as well as the physician and public health nurse can guide the staff in its attempt to provide premises and equipment which insure the safety and well-being of the children. Opportunities may present themselves to the staff to talk with parents about the responsibilities of protecting their children against injuries from accidents.

Emotional problems. A discussion of the emotional needs of the children has not been reserved for the end of this report because these needs are less important or less related to health than the problems discussed earlier. Indeed these children may be as emotionally and culturally deprived as any social group in our country. Those in the health professions are intensely concerned about their needs. The investigations of Bowlby (*6*), Ainsworth (*7*), and others (*8*, *9*) would imply that for children under 2 or 3 years of age, group day care in farm labor settings may be unsuitable and inadvisable. For this age period, every attempt needs to be made to recruit family-group day care. It is conceded, however, that in many rural areas it will be impossible to find families who will care for young children of migrant workers. An alternate solution will need to be explored so that the children under 2 or 3 years of age can be released from their families' automobiles or the care of older siblings. Day care in the centers would be a tremendous improvement. It is certainly conceivable that the babies can be cared for in small self-contained groups. The staff must have a warm interest in babies and provide as great an amount of affection, handling, and stimulation as is possible. The infants need to be spoken to when fed and held and motivated to make sounds and words.

Preschool children must be allowed to develop a sense of autonomy. These children most likely have had only limited opportunities for social development. Perhaps not all of the following

experiences can be built into a rural day care center but as many as possible should be considered. Stimulating toys, play equipment, opportunities for large and small muscle exercise, water play, and art and music expression can add greatly to preventing unhealthy personality development. Older preschool children should be encouraged to assume initiative. Attempts to try out and explore their own interests should not be thwarted but rather encouraged by an understanding staff. The school-aged child requires the praise and support that will lead to the development of a strong sense of accomplishment. The public health nurse, the director, and those in education and social work can collaborate and incorporate into the child care center program the concepts of healthy personality development first proposed by Erik Erikson (*10*).

The environment depicted may not save the mental health of these children, but such an atmosphere may light a candle which can grow brighter and give meaning to otherwise empty lives.

Conclusions

The plight of the adult members of migrant families is generally such that no more than tertiary prevention, the most difficult type of rehabilitation, can be provided. Much more can be done for their children. Child care centers can provide unusual opportunities for primary and secondary prevention of ill health.

Children do not stand still; they grow and develop. If at least part of their environment can be good, they are more likely to grow strong and develop well. But if the environment is predominantly poor, they develop warped minds and bodies and can never reach their inborn potential of becoming valuable citizens of the future.

REFERENCES

(*1*) U.S. Children's Bureau: Children in migrant families. U.S. Government Printing Office, Washington, D.C., 1961.

(*2*) Kansas State Health Department: A report on health and day care services for children of migrant workers. Topeka, 1963.

(*3*) Gilbert, A., and Schloesser, P.: Health needs of migrant children in a Kansas day care program. Public Health Rep 78: 989–993 (1963).

(*4*) Crocker, E. C.: A child welfare worker in a program for migrants. Children 10: 87–92 (1963).

(*5*) Gholz, L. M.: Amebiasis and shigellosis: Long-term prophylactic control. Amer J Trop Med 11: 452–454 (1963).

(*6*) Bowlby, J.: Maternal care and mental health. World Health Organization, Geneva, 1951.

(*7*) Ainsworth, M., et al.: Deprivation of maternal care. World Health Organization, Geneva, 1962.

(*8*) Goldfarb, W.: Emotional and intellectual consequences of psychological deprivation in infancy. *In* Psychopathology of childhood, edited by P. H. Hoch and J. Zubin. New York, Grune & Stratton, 1955.

(*9*) Spitz, R. A.: Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood. Psychoanal Stud Child 2: 113–117 (1946).

(*10*) Erikson, E. H.: Childhood and society. W. W. Norton & Co., Inc., New York, 1963.

SUPPLY REFERENCE

(*A*) Entero-Vioform, supplied by Ciba Pharmaceutical Products, Inc.