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The Health Condition of Migrant Farmworkers

by Edgar Leon, Ph.D.
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The Health Condition of Migrant Farmworkers

Introduction

Despite U.S. government efforts to provide healthcare services to migrant workers, this sector of American society continues to experience problems accessing the healthcare system (Sakala, 1987). High mobility, overcrowded living conditions, demanding work schedules, low income and low educational attainment, discrimination, language, and cultural barriers generally play important roles in migrant workers' health status and health service utilization (Commission on Civil Rights, 1977; 1978; 1983).

Health centers are handicapped in their efforts to focus attention on this deficiency in service by the lack of reliable data on the health status of the farmworkers they serve. While some data are available for individual clinics or regions, this information does not give a clear national picture of the health problems experienced by these workers and their families.

The following study examined many alternate avenues for gathering information about the health conditions of migrant farmworkers. The task of collecting information was arduous because many of the health delivery agencies do not report to the Michigan Department of Public Health. The migrant clinics are federally funded, and this releases them from any state reporting or accountability.

This study will present a synopsis of the health condition of migrant farmworkers in general. The information should not only help predict migrant farmworker health needs for the future, but also provide some ideas for immediate program implementation. Finally, it questions the efficiency of the migrant health delivery model, especially when the clients are mostly transient and without local representation, leaving them vulnerable to be mistreated or abused with no place to complain or request accountability.

Migrants and Poverty-Related Health Problems

Most recent data show that half of migrant farmworker families have incomes below the national poverty level despite the high rate of families with two wage earners (Department of Labor, 1991). Poverty leads to poor nutrition and sanitation, which both contribute to abnormally high rates of chronic illnesses and acute ambiguous problems among migrant children.

Malnutrition has long been associated with poverty. Migrant children commonly suffer from Vitamin A, Calcium, and Iron deficiencies (Koch, 1988; National Rural Health Care Association, 1986). A survey of Florida migrant workers found: many migrant families did not receive food stamps despite their eligibility; 30.6% of the respondents experienced a period during which they ran out or had a shortage of food; and 43.8% experienced seasonal food shortages (Shotland, 1989). Ethnically and regionally, specific dietary inadequacies include zinc, riboflavin, Vitamins B6 and B12, and folate. The study also shows that females among ethnic groups consumed inadequate nutrients more frequently than their male counterparts. An implication is that migrant children suffer from maternal malnutrition.

Migrants and the HIV Infection

Evidence suggests that Hispanic migrants serve as reservoirs of HIV infection upon returning to Latin America. More than 30% of the AIDS cases recorded in Latin America lived in the U.S. (Bronfman, 1993). Other studies indicate that migrants adopt high-risk behaviors under the pressures of migration and may bring HIV infection home to their families in Mexico (de Paloma, 1992, Bronfman and Minello, 1992). The problem of HIV infection among migrant farmworkers in the U.S. takes international importance.

The major HIV risk factors in this population center primarily around unprotected heterosexual intercourse, with IV drug abuse playing a relatively small role. A 1991 survey of migrant farmworkers in Georgia uncovered a previously unreported HIV transmission risk: one-fifth of the migrant population admitted to self-injecting antibiotics or vitamins (Lafferty, 1991). The practice of self-injecting medications has its roots in many Latin American cultures. In Mexico, as in many developing nations, intravenous medications are freely available without prescription. Previous studies in Mexico have shown

that the use of prescribed antibiotics is high, but specific figures regarding the frequency of self-injecting behavior are lacking (McVea, 1995).

In 1996, the *Migrant Health Newsline* reported that language and cultural barriers combined, reducing the knowledge of patient education efforts in the farmworker population. Respondents in a 1988 study of migrant and seasonal farmworkers in Georgia had low levels of accurate knowledge about the AIDS virus. One-third to one-half thought AIDS could be transmitted by sharing a drinking glass, swimming in a public pool, being coughed on, or giving blood. One-fourth answered incorrectly to questions reflecting critical knowledge of transmission routes: 24% did not know that AIDS can be transmitted from women to men, 25.4% did not know it can be transmitted from men to women, and 25.9 % did not know it can be transmitted through sharing hypodermic needles. Over 35% did not realize that AIDS is fatal (Ryan, Foulk, Lafferty and Robertson, 1988).

Research shows that migrants tend to avoid local medical assistance because of high cost of services. Before incurring the cost of a doctor's visit, many farmworkers attempt self-treatment with herbal compounds and other folk remedies. Thus, HIV infection may not be diagnosed until AIDS-related disorders begin to manifest themselves, and HIV may be spread unknowingly by the HIV-positive patient (*Migrant Health Newsline,* 1987).

Some labor camps are composed primarily of single males. This factor, combined with very limited recreational facilities, social isolation, and cultural sanction of prostitution, has resulted in a high incidence of sexually transmitted disease in these camps (Ryan, et all, 1988). A high incidence of both prostitution and intravenous drug use has been observed within some farmworker communities. This is especially true in the east coast stream, where single migrant men interact with day-haul workers from cities with large IV-drug using populations (National Coalition of Advocates for Students, 1995).

In 1996, Meave, Colonius, and Stryker found that there are no HIV zero-prevalence data on migrant farmworkers in Michigan. This severely limits the understanding of the epidemic in this state, and the effectiveness of prevention and intervention efforts. This study also reported the importance of continually building and maintaining collaborative efforts among agencies and community-based organizations that provide services to migrant farmworkers. Collaboration promotes cost-effective, comprehensive, and coordinated services. Ongoing HIV training for staff and other service providers ensures these professionals have current information on which to base training and intervention. Training should serve to reinforce awareness of legal responsibilities, such as confidentiality and changes in prevention and practice policies.

Another important finding reported by this group is that effective service to migrant farmworker communities is enhanced by employing a staff that includes people who are bilingual, bicultural, and originally come from migrant worker families. These staff members can assist in building the cultural competence of the entire staff.

Urgent Areas of Concern

Schmidt affirms that there are five major areas of concern that should be used as an agenda for disease prevention in adolescent migrant farmworkers: (1) substance abuse *[drinking and drug use];* (2) sexuality *[sex education, teenage pregnancy, contraception, sexually transmitted diseases, AIDS, risk factors related to HIV infection, barriers to HIV prevention, and positive programs and practices];* (3) mental health *[psychological stress, family problems, generation and cultural gaps between parents and teenagers, domestic violence, school attitudes, and dropping out];* (4) physical health *[nutrition, dental health, and access to healthcare];* (5) occupational health and safety *[child labor, housing, sexual harassment, field sanitation, and pesticides]* (Schmidt, Aurora Camacho, 1990).

As a result of Mexican illegal migration, many families are not registered with any health organization because they fear being identified by immigration authorities. This issue alone must be studied so that local state agencies can take necessary precaution and monitor the spread of any disease.

The National Resource Program compared migrants' health condition with that of the general U.S. population. They found that:

- migrant farmworkers have different and more complex health problems from those of the general population;
- migrant farmworkers experience more infectious diseases than the general population;
- farmworkers have more clinic visits for diabetes, medical supervision of infants and children, otitis media, pregnancy, hypertension, contact dermatitis, and eczema;
- clinic visits for general medical exams account for only 1.4% of all visits to migrant health clinics, 39% below the U.S. average;
- the farmworker population has more young people and fewer older people than the general U.S. population (NMRP, Inc., 1996).

These statistics alone should question the lack of special attention and illuminate the dire need for additional migrant family healthcare and education.

The Risk of Tuberculosis (TB)

The tuberculosis micro-organism is transmitted primarily by small airborne droplets which are produced when persons infected with tuberculosis sneeze, cough, speak, or sing. Tuberculosis is usually not as infectious as other communicable diseases, but infectiousness varies considerably from case to case. When persons repeatedly share the same air with an infectious patient, they can be infected (Center for Disease Control, 1985). Crowded and dirty housing are also contributors to many illnesses.

Tuberculosis is a constant threat; state health officials estimate that infection rates among farmworkers are about 20 times greater than in the general population. The TB bacillus thrive in the damp, poorly ventilated, congested migrant camps where many people share a single room. State health officials reported three cases of TB among migrants this year — two on the Eastern Shore and one in Albermarle County. This represents less than 1% of the total number of TB cases reported in the state of Virginia. "Tuberculosis is a social disease with a medical aspect," said Dr. Richard Andrews of Eastern Shore Rural Health Clinic in Nassawadodox, Va. which serves migrants. "Of the shore's five clinics, most migrants use this office… you find it with overcrowding, malnutrition, and bad housing" (Stallsmith, 1996).

Many farmers enter the United States from areas of the world where tuberculosis rates are much higher, such as Southeast Asia, Latin America, and Haiti. Tuberculosis in migrant farmworkers presents special problems such as contact examinations, population mobility, fear of deportation, cost, long-term treatment, and other barriers to healthcare (Centers for Disease Control, 1996).

In a 1996 interview, a Muskegon migrant education school director mentioned she had referred various cases of migrant families with TB that were not reported. The migrant director considered these families "high risk" because they are mobile and medical treatment may not be followed according to prescribed instructions. Research shows that TB treatment requires up to six months of continuous medical treatment once the bacilli is identified by the doctor. Many migrant family members may not take their medication after moving because the cough may disappear, and access to hospitals, clinics, or pharmacies may be impractical (Ochoa at el, 1983).

Migrant farmworkers have also requested more TB prevention education be provided in Spanish for all migrant families (Muskegon, 1996). It has been shown that printed brochures are not an effective form of intervention (Alfaro, 1996). Brochures may be a cost-efficient option, but it is far from effective in reaching all the infected population. The best tools for reaching this population are radio, television, and direct, person-to-person family health education.

Much more research is needed in this area of concern. Mexican Migrant Farm Workers (MMFW) perceived unfamiliarity with community medical care services, lack of communication, and conflicts with job schedules as obstacles in seeking the most basic

medical attention. For example, if health providers are monolingual English speakers, it is difficult to communicate important medical information to Spanish monolingual migrant workers on how and when to take their medication. Many farmworkers rely on folk medicines, believe in self-administered treatments, and suffer from such maladies as *Mal de Ojo, Caida de la Mollera, Susto,* and *Empacho* (Bogue, 1983).

In a 1993 study done by Ochoa, et. al, the most common health problems reported among migrant households were dermatological problems, and musculo-skeletal ailments such as swollen joints, back pain, and joint dislocations.

Migrant Worker Health Concerns

When asked about their health concerns, migrant farmworkers voiced the following issues in relation to specific needs and accessibility of health services:

- migrant health clinic hours are inconvenient for migrant farmworkers because they fall within the working day;
- health clinic waiting room space is very limited. This forces farmworker families to wait outside the clinic or in their cars;
- illegal aliens sometimes do not frequent the clinics because they fear being caught by immigration officials;
- additional mobile clinics are needed in order to reach people who have no access to transportation;
- more migrants want to apply for Medicaid, but some lack the language and educational skills to correctly complete the required forms;
- migrants need supplemental resources to Medicaid; sometimes medical service costs exceed Medicare's meager coverage (Migrant Farmworker Conference, 1995).

Other reasons or problems were also stated, although not necessarily reported. Out of frustration, migrant families often select other means of healthcare that are readily available and not as costly as ones available in the city or state where they relocate to. Bogue (1991) reports that migrant families often select treatments in the following sequence: they first prefer a medical doctor, then choose drug store remedies; if those are unavailable, many farmworkers then attempt home remedies and, finally, utilize a healer. About 35% of the health problems experienced by MMFW members were treated by self-prescribed, over-the-counter medication. Drug stores and healthcare centers are usually far removed from rural areas; this makes it more crucial, yet difficult, for migrant families to have localized healthcare access. Future health education should focus attention on this important subject.

Migrant farmworkers have voiced these concerns for many decades, but the lack of political support at local, state, and federal levels of government leaves them at a disadvantage. The need for school health advocates, at all grade levels, is critical. Because of migrants' movement from state to state, it is very difficult to keep all the health and immunization record requirements in order. The following section discusses this issue in some detail.

Confusion About Medical Needs

Migrant student health records show that immunization records are frequently not updated by health or school officials. This may lead to children being overvaccinated as they move from community to community. Spanish-speaking parents may not understand that these inoculations are being duplicated, and they can put their children at risk by instilling their faith in a misinformed school official. In addition, vaccination record forms are frequently not compatible between sending and receiving states. Languages, formats, and information requirements vary from state to state, and between countries. There have been some attempts to standardize the vaccination forms, but this issue remains unresolved.

Mexican government officials and the U.S. Department of Education have created a bi-national health card for distribution in both countries to facilitate the standardization of such information. The plan calls for each school receiving or sending students across the border to provide a set of health cards that accompanies the students. This would make it easier for Mexican and U.S. schools and health officials, and prevent the duplication of vaccinations (Binational Program, 1996).

Child Abuse and Domestic Violence

There are many cases of domestic violence that become medical emergencies. Because of drug and alcohol abuse, there are increased dangers for migrant families. Cases should be tracked and monitored by local health and social service authorities so children are not negatively affected at an early age. Local sheriff and police must make additional efforts to document and report these cases. Prevention programs and education must also be initiated in order to halt instances of abuse and violence.

Cigarette Smoking

U.S. records show that Hispanics have some lifestyle factors that place them at lower risk than Whites for some types of diseases. Among them, based on the 1991 U.S. National Health Interview Survey, is that cigarette smoking is more prevalent among Whites that among Hispanics. The lack of medical treatment and nutrition also appear to be negative factors contributing to health problems.

Secondhand smoke is also a serious health problem for infants among the migrant population. It is well known that the children of smokers have significantly higher instances of upper respiratory infections, sinus infections, and ear infections. Studies also show that infants growing up in the home of smokers may develop smaller lung capacity as well as other chronic respiratory afflictions.

Inhaled secondhand smoke also significantly contributes to coughing and sleeping problems for children. The airways have irritant receptors which are stimulated by ingredients of tobacco smoke and can cause not only coughing, but increased mucous production, nasal stiffness, and bronchial asthma. Schools, community advocates, and migrant health clinics should target migrant families through public announcements and education programs. Both Spanish and English must be used in the development of such material (Family-e-docs, 1996).

Environmental Pollution

According to 1995 reports from the MDPH, 22% of Michigan Hispanics are exposed to very high air pollution in the counties of Allegan, Benzie, Berrien, Delta, Kent, Macomb, Mason, Muskegon, Oceana, Ottawa, and St. Clair. Potential dangers related to air pollution and risks of high exposure were not mentioned by the MDPH.

Researchers should re-examine the effects of pesticides, fertilizers, and other environmental contaminants on Michigan's migrant families. The strength and applicability of these herbicides, pesticides, and fertilizers has increased dramatically in the past decade. Researchers must be encouraged to explore the working and living conditions of Michigan's migrant farmworkers. Additional research is recommended to identify high incidences of cancer, dermatology problems, or cardiopulmonary diseases that are often associated with prolonged exposure to pesticides and fertilizers. Farmworkers' health records, like the school records of their children, do not adequately reflect the realities of the situation.

Usage of Other Drugs

Several reports suggest that recreational drug usage is much lower among Hispanics than among Whites and African Americans in the U.S. The 1991 National Household Survey of Drug Abuse (NHSDA) found that among young adults age 18-25, 53% of Hispanics, 56% of African Americans, and 67% of Whites reported using alcohol within the previous month. Marijuana use was reported less often with only 9% of Hispanics reporting such usage as compared to 14% of Whites and 15% of African Americans. Although use of cocaine was reported by a larger percentage of Hispanics (1.3%) than of Whites (0.3%) or African Americans (0.5%), the standard errors of these percentages were too large to suggest real differences.

There is no reason to conclude that these tendencies and behaviors are reflective of all migrant farmworker families. During informal conversations with migrant recruiters and migrant education directors, it was suggested that migrant adults and teenager males use alcohol primarily as a means of recreation. Testimony from some migrant female farmworkers interviewed by this researcher supports this statement.

Poor Nutrition

A nutritional health risk that is usually high among Hispanics and migrant families is obesity. The 1982-84 U.S. Hispanic Health and Nutrition Examination Survey showed that the prevalence of obesity for Hispanic women age 20-74 was 39% for Mexican Americans, 34% for Cuban Americans, and 37% for Puerto Ricans (U.S. Public Health Service, 1990:93). These rates were well above the general U.S. population age 20 and over.

A 1988 study also concluded by the Michigan Department of Public Health suggested that the prevalence rate of diabetes was higher for Hispanic men (8.7%) and women (l0.5%) than the general U.S. population (5.5%). The high fat foods and cooking components, and the high use of sugars, could be some of the negative factors contributing to this high prevalence rate.

Infectious Diseases and Vaccinations

Hispanics and Whites in Michigan had a similar annual incidence rate of Hepatitis B in 1989-91, and Hispanics had an incidence rate of measles that was less than half that of Whites. However, Hispanics faced close to twice the incidence rate of AIDS, more than 2.5 times the incidence rate of tuberculosis, and about 11 times the incidence rate of syphilis. It is easy to suggest that migrant Michigan families are exposed to these diseases because they interact with other Hispanics in town.

Most migrants are Hispanic, and they frequent the same churches, schools, community centers, social service offices, migrant clinics, bars, supermarkets, sporting events, and restaurants as other Hispanics in the community. Efforts must be made to immunize all children regardless of race, color, and religion; migrants are more likely to miss some vaccines because of their constant movement. This mobility prevents migrant mothers from vaccinating their children on a regular basis. Not all migrant mothers are well-educated about immunizations. Most migrant mothers ignore the fact that "vaccines induce an immune response to a specific bacterial or viral infection," and therefore provide protection against diseases caused by these organisms (North American Vaccine, Inc., 1996).

Experience in the United States in recent years illustrates both the effectiveness of immunization and the tragic consequences of failing to vaccinate properly. Before the measles vaccine was approved in 1963, more than 500,000 cases were reported each year, killing 400-500 people annually. By 1983, the number of cases of measles reported dropped to a record low of 1,497. However, a resurgence of measles between 1989 and 1991 — more than 55,000 cases of measles, including 132 reported deaths — occurred primarily among unvaccinated pre-school children. In 1990, 64 individuals died of measles, the highest number in two decades. The greatest cause of this measles epidemic was the failure to vaccinate children on time at 12-15 months of age (North American Vaccine, Inc., 1996).

It is important to recognize that all children must be immunized against 10 diseases. These include diphtheria, tetanus, pertussis, polio, haemophilus influenzae type b, measles, mumps, rubella, hepatitis B, and varicella. All, except tetanus, are contagious and transmittable.

Diphtheria - an infection of the throat, mouth, and nose, which can cause heart failure or paralysis if untreated.

Tetanus (lockjaw) - an infection that attacks the nervous system, and kills 10% of infected people.

Pertusis (whooping cough) - highly contagious, causes severe coughing and occurs most frequently in children under five years of age.

Polio - causes paralysis and is life threatening.

Measles - highly contagious, causes rashes and high fever; during the 1989-1991 measles epidemic, 19% of persons with measles were hospitalized.

Mumps - causes fever, headache, and inflammation of the salivary glands, three of every 10 infected people develop meningitis, an inflammation of the covering of the brain and spinal cord.

Rubella (German measles) - causes fever and rash, and results in severe birth defects when pregnant women are infected.

Haemophilus influenzae type b (Hib disease) - contracted by one out of every 200 children before the age of five prior to the availability of vaccines; affects blood, joints, bones, and the covering of the heart. Hib disease is the most common cause of serious bacterial meningitis in children.

Hepatitis B - causes cirrhosis of liver and cancer.

Varicella (chicken pox) - causes a rash and fever, is highly contagious, and can attack the central nervous system.

It is recommended that migrant education staff members contact the nearest health clinic or family doctor to get a schedule for each type of vaccine. Schools may also require a child to have all vaccines taken and updated before the student is accepted into classes. Variations from state-to-state opens the possibility of overimmunizing children each time they move from one state to another. Another problem may occur when children are underimmunized. The lack of interstate coordination sometimes forces the migrant family to carry multiple vaccination cards.

Migrant Family Dental Needs

Research shows that dental disease in this country is, for the most part, a disease of poverty. In Washington state, 20% of the population has over 80% of the disease; 20% of the population are migrant farmworkers who traditionally seek public healthcare (Koday, 1995). It should be noted that the same conditions may be replicated all over the United States. Migrant families show similar economic conditions, regardless of the state where they reside.

Dental care is sometimes difficult for farmworker families to obtain because many dentists are not established in the rural areas. This often causes migrant families to travel long distances for basic care and services. More and more dentists also require participation in an accepted dental health plan, which most farmworkers do not have. Koday (1995) mentions that a couple of "bite wings" and "PA radiograph" are simply not enough for proper diagnosis. Complete soft tissue exams, including lymph node palpitation, are required — not just desired. Dental clinics should provide periodontal diagnosis for all patients, full-mouth pocket charting, and treatment as indicated. Farmworker dental charts should be considered incomplete if they do not include updated medical histories of the patients.

Clinical quality standards must not be based on what the nurses or dentists feel is appropriate, but on appropriate and acceptable state and federal guidelines. Clinical circumstances and environments must not dictate medical practice. It is understood that private or public migrant dental clinics cannot provide every service, but those provided must be of the highest quality available.

Migrant Children with Disabilities

Children with Down Syndrome and other multiple handicapping conditions must quickly be identified and served by the local school systems. About 10% of migrant students require special education and may require medical assistance. They often lack special attention due to constant relocation of their family. Migrant children with disabilities may not be encouraged to go to school because of the need for specialized transportation and lengthy evaluations.

Careful monitoring and reporting programs of all migrant special education children must be in place to serve children with immediate needs. The lack of school funds and mid-term arrival in school districts must not keep students at home nor prohibit their participation in the regular school program. Parents must request evaluations and school placement without delay. School administrator must make honest efforts to adequately serve these students.

This list includes the top four major barriers to healthcare for migrant children with disabilities:

1. Lack of transportation;
2. Language barriers (local staff cannot understand or speak Spanish);
3. Parents lack of knowledge about special education rules and regulations;
4. Cost of testing.

Schools must make a genuine effort to assist disabled migrant children and provide the best possible services available.

Expectations of Latino Health Professionals

Latino health professionals are expected to serve as translators for every person in the clinic. Latino health professionals are hesitant to serve as a translator for the same amount of pay. Specific personnel must be hired to accomplish the task of translating so that valuable health professional time is used wisely. Coordination with the local community centers and hospitals should be made so that they can share resources or personnel to assist with this great need.

Medical Insurance and H.M.Os

Hispanics in the Michigan have higher rates of unemployment and poverty than Whites. Thus, Hispanics do not have the same opportunity to secure employer-funded health insurance or to purchase health insurance with their earnings. Most migrants depend on local community centers, migrant clinics, and, in difficult times, local "curanderos." The following presents several HMOs that are available in Michigan. Migrant families may qualify for some of these services if they are identified and referred to them on a regular basis.

Medicaid (Medical Assistance, MA) provides minimal medical care to recipients of Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) and other low income people who are under 21, pregnant, disabled, blind, or age 65 and older. Coverage includes hospitalization, home and nursing home health care; physician, dental, podiatrist, and limited chiropractic services; x-ray and lab tests; vision, hearing, and speech services; maternity and family planning services; infant and maternal support services; pharmacy and ambulance services; substance abuse services; and diabetes education.

The State Medical Program (SMP) provides basic ambulatory medical care to low income people who do not qualify for Medicaid. Those eligible may be adults in the State Family Assistance program, recipients of the State Disability Assistance program who do not qualify for Medicaid, and other low income people. Participation in the plan is limited and does not include hospitalization. An average of 51,757 patients are eligible each month.

Recommendations

The following are recommendations to state agencies so they can improve the health delivery system to migrant families. Each particular region should use the resources available based on their priorities to better serve the migrant families of its area. State agencies must concentrate on mobile migrants first because they have the most need of services.

1. Set high quality standards for comprehensive school health programs. Provide technical assistance, resources, translation, and coordination of services to local education agencies seeking to conduct comprehensive health education programs that are culturally appropriate;

2. Review state guidelines to ensure local education agencies are responsible for social, emotional, and psychological needs of youth;

3. Set high quality standards and provide technical assistance, resources, and coordination of services to local education agencies seeking to reduce inter-group tensions by mandating a school curriculum that celebrates the cultural contributions of all students;

4. With the help of community-based organizations rooted in ethnic communities, create innovative state and local action plans to involve parents in their children's education, to encourage them to become partners with educators, and to support their children's learning at home;

5. Enlist the help of educational institutions, like state universities, to conduct evaluations of health programs;

6. Coordinate migrant education and health programs to address all aspects of adolescent farmworkers' health;

7. Request that colleges and universities develop programs to train and certify bilingual and bicultural health counselors recruited from the farmworker community (U.S. Department of Labor report - Agricultural Workers Survey [NAWS] 1990: A demographic and Employment Profile of Perishable Crop farmworkers).

The Ideal Healthcare System

The ideal healthcare delivery system, according to the Migrant Clinicians Network group, must be involved in all areas that affect farmworkers' health. Examples include housing, unemployment, worker's compensation, immigration and citizenship regulations, and access to healthcare.

The system must provide comprehensive healthcare services incorporating the following:

- preventive care;
- health maintenance programs;
- health screenings;
- oral health clinics;
- mental health clinics;
- substance abuse prevention programs;
- social services.

The system must provide services in a manner which is appropriate to farmworkers' culture and lifestyle. Barriers which impede access to services must be reduced by providing transportation and child care, expanded (evening and weekend) clinic hours, multiple service provision sites, outreach programs, and other services. Healthcare providers, clinic staff, and patient education materials must be appropriate to farmworkers' language and reading skills, cultural values, behaviors, and lifestyles.

The system must be developed instituting services based on documented needs. Involvement of individuals, families, and communities is critical in the development of services for farmworkers. Efforts must maximize interagency coordination and integration in order to offer universal access for farmworkers, require minimal documentation for registration and reporting, and ensure interstate reciprocity as farmworkers travel along the migrant stream.

The system must aggressively recruit multilingual, multicultural healthcare providers and other staff. healthcare services should be provided by a multi disciplinary team. In addition, the system must allow the personnel to allocate time for case management and practice-based research, rather than basing productivity solely on the number of patients.

The system must use a centralized, standardized database for collection of data on farmworkers, transdental hygienists, and community outreach workers.

Finally, outreach programs which emphasize screening and needs assessment suffer from the lack of a streamlined system for the transfer of medical records. It is very difficult to conduct comprehensive health screening and needs assessment for patients in the absence of reasonably complete medical history (Migrant Clinicians Network, Inc., 1992).

Need for Additional Research

There is a great need for accurate facts about the number of migrant farmworkers and their families, their health problems, birth rates, accident rates, and other important information. It is shameful that the state of Michigan counts wildlife more accurately than they do migrant families. Without this crucial information, it is difficult to recommend plans, implement changes, and project budgets for immediately-needed migrant support programs. Continuous research must be done to provide reliable migrant health information and to help prevent migrant school discontinuity. The more we know about children's health, the more we can plan and the less time migrant students and families have to spend in line to be served at a migrant clinic or hospital.

Transportation, access, culturally-sensitive staff, and language barriers appear to be the greatest influences for migrant healthcare decisions. Research must include accurate and reliable data that identify these and other problems.

As part of this paper, Appendix I summarizes immunization requirements for children attending Michigan childcare programs and schools. A primary healthcare physician may recommend a different schedule based on the patients specific needs. This is merely a guide for those who need an immediate reference. It may help to find the differences and similarities with other sending states and countries (such as Texas, Florida, Mexico, and Puerto Rico) so that migrant programs can plan migrant family healthcare delivery systems ahead of time.

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Appendix A

Tome la Decision Correcta… Vacunelos!

Estas son las vacunas que todos los niños necesitan:

Al tiempo de recien nacido: Hepatitis B

2 meses de edad: DTP (difteria, tetano y tosferina)
Hepatitis B • vacuna oral para el polio • *vacuna contra Hepatitis influenza typo b (Hib)*

4 meses de edad: DTP, vacuna oral para el polio, y Hib

6 meses de edad: DTP y Hib (depende que vacuna se use para Hib)

6 a 18 meses de edad: Hepatitis B y vacuna oral para el polio

12 a 15 meses de edad: Una dosis de refuerzo de Hib

MMR (sarampión, paperas y sarampión alemán)

12 a 18 meses de edad: DTP

4 a 6 años de edad: DTP, vacuna oral para el polio, y MMR

14 a 16 años de edad: Td (tetano y difteria)

Todos los padres deben traer consigo una copia del record de immunización de sus hijos. Las vacunas son ofrecidas en los departamentos de salud locales, o en las oficinas medicas privadas a un costo bajo, o gratuito. A nadie se le negará vacunas en el departamento de salud por no tener dinero con que pagar.

Es importante immunizar (vacunar) niños a tiempo, para que sean protegidos contra enfermedades de infancia.

Be Wise… Immunize!

These are the vaccinations every child needs:

At Birth: hepatitis B

2 months old: DTP (diphtheria, tetanus and pertussis) • hepatitis B, oral polio • *Haemophilus infulenzae* type b (Hib)

4 months old: DTP, oral polio, and Hib

6 months old: DTP, and Hib (depends on which brand of vaccine is used)

6-18 months old: hepatitis B, oral polio

12-15 months old: Hib booster, MMR (measles, mumps, and rubella)

15-18 months old: DTP

4-6 Years: DTP, oral polio, and MMR

14-16 Years: Td (tetanus and diphtheria)

All parents should carry a copy of their child's immunization record card with them at all times. Immunizations are available from local health departments at little or no cost as well as from private doctors. No one will be denied vaccination at a local health department because of an inability to pay.

It is important that children are immunized on time to fully protect them against early childhood diseases. Call your local health department for more information.