DOCUMENT RESUME

ED 406 074 RC 020 882

AUTHOR Leon, Edgar
TITLE The Health Condition of Migrant Farm Workers.
SPONS AGENCY Michigan State Dept. of Education, Lansing.
PUB DATE Jan 96
NOTE 18p.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS At Risk Persons; *Communicable Diseases; *Delivery Systems; Elementary Secondary Education; Health; Health Education; *Health Needs; Hispanic Americans; Migrant Children; *Migrant Health Services; Migrant Problems; *Migrant Workers; Migrant Youth; Nutrition; Poverty; Role of Education; Work Environment
IDENTIFIERS Access To Health Care; *Health Status; *Michigan

ABSTRACT

This report examines information about the health status of migrant farmworkers, including specific issues related to migrant health services in Michigan. Despite the high rate of families with two wage earners, one-half of migrant farmworker families have incomes below the poverty level. Poverty is associated with poor nutrition and sanitation, which contribute to abnormally high rates of chronic illnesses and acute problems among migrant children. Evidence also suggests that due to misconceptions and lack of information, Hispanic migrants are spreading HIV in the United States and their native countries. Major health issues for adolescent migrant farmworkers include substance abuse, sexuality, mental health, physical health, and occupational health and safety. Another area of concern is tuberculosis, which occurs about 20 times more frequently among farmworkers than the general population. Other health care issues related to migrant farmworkers include confusion about medical needs, domestic violence, cigarette smoking, environmental pollution, drug abuse, poor nutrition, infectious diseases and vaccinations, childhood immunizations, dental health, disabled migrant students, expectations of Latino health professionals, and medical insurance. Recommendations to state education agencies for improving the health delivery system to migrant families by schools and local education agencies are included (pages 10-11), and the characteristics of an ideal health care delivery system for farmworkers are described. Contains 23 references and child immunization schedules in English and Spanish. (LP)

THE HEALTH CONDITION OF MIGRANT FARM WORKERS

By: Edgar Leon

The Health Condition of Migrant Farm Workers

by Edgar Leon, Ph.D.
note: Dr. Leon is a Migrant Education Consultant for the Michigan Department of Education, Lansing, Michigan - January 1996

Introduction:
Migrant farm workers are considered high risk because they are exposed to dangerous chemicals and pesticides either directly or indirectly. The exposure to such materials will happen over long periods of time. Many families have potential risks of having children with birth defects or simply are subject to cancer and other illnesses. Many of the general population behaviors are also filtering into the migrant stream. Teen pregnancy is present and the use of controlled substances and alcohol is still a major problem. Reading and writing skills using the English language is a great need for the monolingual farm worker families. In many cases, families may have a very hard time completing the medical forms and histories because they lack the basic English skills.

Despite the efforts the United States has made in providing health care services to migrant workers, they continue to experience problems accessing the health care system (Sakala, 1987). High mobility, overcrowded living conditions, demanding work schedules, low income, low education, discrimination, language, and cultural barriers may 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 gap 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 author went through many alternate avenues for gathering the actual information. The reader must use the material presented in the proper perspective. The information should not only help you predict the migrant farm worker health needs for the future but also some ideas for immediate program implementation.

The following study will provide the reader with an over all synopsis of the health condition of the migrant farm worker in Michigan. It is to be said that the task of collecting information was very difficult because many of the health delivery agencies do not report'to the state department of Public Health. The migrant clinics are federally funded and this releases them from any state reporting or accountability. We must question the efficiency of this health delivery model, especially when the clients are mostly transient and with no local representation. This condition leaves them vulnerable to be mistreated, abused, ignored and with no place to complain or request accountability.

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

Malnutrition is 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 (Shotland, 1989) found that many migrant families did not receive food stamps despite their eligibility; that 30.6 percent of the respondents experienced a

period during which they ran out or had a shortage of food; and the 43.8 percent of them had seasonal food shortages. Ehtnically 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 signifanctly more frequent than males. 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 return to Latin America. More than 30% of the AIDS cases lived in the US (Bronfman 1993). Other studies indicate that migrants adopt high-risk behaviors under the pressures of migration, and may then bring HIV infection home to their families in Mexico (de Paloma 1992, Bronfman and Minello 1992). Thus the problem of HIV infection among migrant farm workers 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 farm workers in Georgia uncovered a previously unreported HIV transmission risk: One fifth of the migrant admitted to self-injecting antibiotics or vitamins (Lafferty 1991). The practice of self injecting medications has its roots in the Latin American cultures from which Hispanic farm workers derive. In Mexico, as in many developing nations, intravenous medications are freely available without prescription. Previous studies in that country have shown that the use of prescribed antibiotics is high, but specific figures regarding the frequency of self injection behavior are lacking. (McVea 1995)

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

Research shows that migrants tend not to seek local physicians assistance due to high cost of services. Before the cost of going to a doctor, many farm workers will attempt self-treatment with herbal compounds and other folk remedies. Thus, HIV infection may not be diagnosed until AIDS-related disorders begin manifesting, 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 saction 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, especially in the east coast stream where single migrant men interact with day-haul workers from large cities with large IV-drug-using populations. (National Coalition of Advocates for Students, 1995)

Meave, Colonius, & Stryker (1996) found that there are no HIV sero-prevalence data on migrant farmworkersin Michigan. This severely limits our understanding of the epidemic in this state and the effectiveness of prevention intervention efforts.

They also reported that it is important to continue building and maintaining collaborative efforts among agencies and community-based organizations providing services to migrant farm workers. Collaboration promotes cost-effective, comprehensive, and coordinated services. They add that Ongoing HIV training for staff and other services providers ensures they have current information on which to base training and interventions. Training for service providers should be ongoing and should especially include reinforcing awareness of legal responsibilities such as confidentiality and other changes in prevention and practice policies.

Another important point reported by this group is that effectiveness in serving the migrant farm worker community is enhanced by empoying a staff that includes people who are bilingual, bicultural, and come from migrant worker families. These staff members can build the cultural competence of the entire staff.

Urgent Areas of Concern

Schmidt (1990) affirms that there are five (5) major areas of concern to be used as an agenda for health prevention of adolescent migrant farm workers. (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 gap and cultural gap between parents and teenagers, domestic violence, school attitudes, and dropping out); (4) physical health (nutrition, dental health, and access to health care); (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 to be identified by immigration authorities., This issue alone must be studied so that local state agencies take necessary precautions and prevent the spread of any disease.

The National Resource Program compared the migrant health condition with 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 suffer more infectious diseases than the general population.

Farmworkers have more clinic visits for diabetes, medical supervision of infants and children, otitis media, pregnancy, hypertension, and contact dermatitis and eczema.

Clinic visits for general medical exams account for only 1.4 percent of all visits to migrant health clinics, 39 percent 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 make us question the lack of special attention and the need for additional migrant family health care. They also substatiate the need for migrant family health education.

The Risk Tuberculosis (TB) Spread

The tuberculosis organism is transmitted primarily through the air on small airborne droplets which are produced when persons with tuberculosis of the lung or larynx sneeze, cough, speak, or sing. Tuberculosis is usually not as infecttious as some other communicable diseases

such as measles, but infectiousness varies considerable from case to case. When persons repeadly share the same air with an infectiuos patient, they can be infected. (Center for Disease Control, 1985)

Crowded and dirty housing also causes many illnesses. Tuberculosis is a constant threat, with rates among farm workers about 20 times greater than in the general population, state health officials estimate.

The TB bacillus thrive in the damp, poorly ventilated, congested migrant camps, where many people may share a 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 percent of the total number of TB reported in the state of Virginia. "Tuberculosis is a social disease with a medical aspect, " said Dr. Richard Anrews of Eastern Shore Rural Health Clinic in Nassawadodox, which serves migrants. Of the shore's five clinincs, most migrants use this office. " You find it with overcrowding, malnutrition and bad housing." (Satllsmith 1996)

Many farmers enter this country from areas of the world where tuberculosis rates are much higher than in the U.S., such as south Asia, Latin America, and Haiti. Tuberculosis in migrant farmworkers presents special problems because of the need for long-term treatment or preventive efforts, contact examinations, population mobility, fear of deportation, cost of treatment, and other barriers to health care. (Centers for Disease Control, 1996)

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

Migrant farmworkers have requested that more TB health prevention education be provided in Spanish for all migrant families. (Muskegon, 1996) It has been shown that printed brochures are not an effective way of intervention (Alfaro, 1996). It may be the less costly but it is far from reaching all the infected population. The best tool for reaching this population seems to be radio, television, audio cassettes and direct person to person family health education.

Much more research is needed in this area of concern. Mexican Migrant Farm Workers (MMFW) perceived communication barriers, unfamiliarity with community medical care services, and conflicts with job schedules as obstacles seeking medical attention. For example, if the health providers are monolingual English speakers it would make it very difficult to communicate important medical information to Spanish monolingual migrant workers on how and when to take their medication. MMFW believed in, and suffered from, such folk diseases as Mal de Ojo, Caida de la Mollera, Susto and Empacho, and were familiar with folk therapy. (Hilda Ochoa Bogue, R.N., M.S., CHES, Pi Chapter, Kelli McCormack Brown, Nancy P. Parsons, Kathy Fisher "Health Care Needs of Mexican Migrant Farm workers in Rural Illinois: An Exploratory Study, The Heath Educator, Fall, 1983, P.27-32.

In a study done by Ochoa, CHEZ, Brown, Parsons and Fisher (1993), The most common health problems reported among the 39 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 farm workers voiced the following issues in relation to specific needs and accessibility of health services.

.Migrant health clinic hours are inconvenient for migrant farm workers because they fall within the working day.

. Health clinic waiting room space is very limited. This forces the farm worker family 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 the people in need.

. More migrants need to apply for Medicaid but sometime lack the language skills and education to correctly complete the forms.

. Migrants need supplemental resources to Medicaid. Sometimes the medical service cost is very high and Medicare alone is not enough. (Migrant Farmworker Conference 1995)

It is clear that the migrant farm workers have been voicing these concerns for many decades but the lack of political support at the local, state and federal levels of goverment leaves them in a dissadvantaged position. The needs for school health advocates at all grade levels is crucial so that all the concerns are written and voiced every year, but to ensure that they are dealt with immediately to prevent health diseases and potential school drop out rates. Because of the migrant movement from state to state, it makes it very difficult for them to keep all the health and immunization record requirements in order. The following section will discuss this issue with some detail.

Confusion About Medical Needs

Migrant student health records show that immunization records are not frequently updated by health or school officials. This may create a double vaccination situation to the migrant child. In addition, vaccination record forms are not compatible between sending and receiving states. Languages, formats, and information requirements are different from state to state and from other countries. There have been some attempts by the sending and receiving states to standardize the vaccination forms but this issue is still not resolved and much coordination is still required.

Mexican government officials and the US Department of Education have created a bi-national health card to be distributed in both countries in order to facilitate the standardization of such information. The plan is to provide each school that receives or sends students from or to Mexico a set of health cards so that the mexican student can bring back home or take to the next school. This would make it easier for mexican and US schools and health officials and prevent non or double vaccination conditions. (Binational Program 1996)

Other special health issues that need to be discussed because of the lack of services provided in these areas are: Child and Spouse Abuse, Mental Health, and Safety Education.

Spouse and Child Abuse and Domestic Violence

There are many of these cases that could become medical emergencies and that are hidden from the general public. Because of drug and alcohol abuse there is a potential danger for the migrant family. These cases must be tracked and monitored by local health and social services authorities so that the child is not affected at an early age. Local Sheriff and police must make an effort to

document and report these cases to the local and state authorities. Prevention programs and education must be in place in order to prevent abuse and domestic violence from happening.

Problems quoted by interviews with migrant families 1. I don't speak the language 2. I didn't know which doctor to go to 3. I couldn't lose a day of work 4. I didn't have transportation 5. I didn't have enough money to pay 6. I didn't have anyone to care for the children 7. The doctors don't see walk-in patients 8. The appointments dates were too far off 9. The doctors wouldn't give appointments 10. I didn't have a telephone 11. I didn't believe in doctors Other reasons or problems were also stated but not reported.
Out of frustration migrant families select other means of health care that are readily available and do not cost as much as the ones available in the city or state they move too. Bogue (1991) reports that migrant families select the sequence of treatments in the following sequential order. They will choose a medical doctor, drug store remedies, home remedies, healer and other sources when one of the first are not available to them. Drug stores and health care centers are usually far away from the rural areas. This makes the need more urgent and difficult for the migrant families. According to recent research about 35% of the health problems experienced by the MMFW were treated by self-prescribed, over the counter medication (such as intravenous penicillin), future health education may focus attention on this important subject.

Cigarette Smoking
US records show that Hispanics have some lifestyle factors that place them at lower risk than whites for some types of diseases. It appears that cigarette smoking is more prevalent among whites that among Hispanics. This is based on the US National Health Interview Survey of 1991. Since Hispanics in Michigan appear to have lower death rates from lung cancer and bronchus than white residents, Michigan Hispanics probably have smoking patterns similar to Hispanics in other parts of the country. We must be careful not to generalize this behavior to the migrant farm worker population. Some lung diseases such as tuberculosis may be present due to contamination from Mexico or the precenceof pesticides in and out of state farms. The lack of medical treatment and nutrition also appear to be negative factors which contribute to this health problem.

Second hand smoke to infants is a serious health problem among our migrant population. It is well known that the children of smokers have significantly higher incidence of upper respiratory infections, sinus infections, and ear infections. There are also studies that show that infants growing up in the home of smokers may develop smaller lung capacity as well as other chronic lung conditions.

It is also a fact that the inhaled smoke is significantly contributing to the child's coughing and sleeping problems. The airways have irritant receptors which are stimulated by ingredients of tobacco smoke and can cause not only coughing but increased mucous production, nasal stifness, and bronchial asthma. Schools, community avdocates, and migrant health clinics should target the smoking prevention public announcements and education towards migrant families. Efforts must be made to deliver the information inside the camp, in churches or the office of community health. Both languages Spanish and English must be used in the development of such material. (Family-e-docs, 1996)

Environmental Pollution
According to reports from the MDPH 1995, twenty two percent of Michigan Hispanics' are exposed to very high air pollution. These are residing in Michigan counties that not meet the National Air Quality Standards in 1991. The high pollution counties are: Allegan, Benzie, Berrien, Delta, Kent, Macomb, Mason, Muskegon, Oceana, Ottawa, and St. Clair. Potential dangers and risks of high exposure were not mentioned by the MDPH.

Research must be done to explore the effects of pesticides or fertilizers on the Michigan migrant families. Researchers must be encouraged to explore the condition of Michigan migrant families

and how much of the illnesses are related to job and field contamination. Additional research is recommended to identify high incidence of cancer, skin problems or cardiopulmonary disseases as result of very high pollution. We may conclude that migrant families are located in most of these counties and are also exposed to high air pollution.

Usage of Other Drugs

Several reports suggest that the usage of recreational drugs other than nicotine is much lower among Hispanics than among whites and African Americans in the US. The 1991 National Household survey on Drug Abuse (NHSDA) found that among young adults (*aged 18-25), 53% of Hispanics, 56% of African Americans, and 67% of whites reported using alcohol within the previous month. Usage of marijuana was less often reported by any of the three groups, but only 9% of Hispanics reported such usage as compared to 14% of whites and 15% of African Americans. Although usage 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.

This may not be a reason to conclude that these tendencies and behaviors are also carried by the migrant farm worker families. This researcher did not find any recent study which reflects the drug use and behaviors of the migrant worker. It has been suggested during informal conversations with migrant recruiters and migrant education directors that migrant adult and teenager males are using alcohol as means of recreation. Testimony from some of the migrant farm worker adult females interviewed by this researcher support this statement.

Poor Nutrition

A nutritionally health risk that is usually high among Hispanics and migrant families is obesity. The 1982-84 US Hispanic Health and Nutrition Examination Survey showed that the prevalence of obesity for Hispanic women aged 20-74 were 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 US population aged 20 and over.

A study done by the Michigan Department of Public Health (1988) suggested that the prevalence rates of diabetes were higher for Hispanic men(8.7%) and women(10.5%) than the prevalence rates of the general US population(5.5%). The foods and cooking components of high fat and eating other high fat meats and 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, 2.7 times the incidence rate of tuberculosis, and about 11 times the incidence rate of syphilis. It is easy to suggest that the migrant Michigan families are exposed to these diseases because they will interact with other Hispanics in town.

Most migrants are Hispanic and will be frequenting the same church, schools, community centers, social service office, migrant clinics, local bars, supermarkets, local sport events and local restaurants as any other Hispanic from town. Efforts must be made to immunize all children regardless of race, color, and religion. Migrants are more succeptible to miss some of the vaccines because of their constant movement. These conditions could prevent migrant mothers from vaccinating their children on a regular basis. It is also a fact that not all migrant mothers are well educated in the theory of immunization. Most migrant mothers ignore 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 has illustrated both the effectiveness of immunization and the tragic consequences of failure to vaccinate properly. before the measles vaccine was approved in 1963, more than 500,000 cases were reported each year, killing 400 to 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, 1ncluding 132 reported deaths) occurred primarily among unvaccinated pre-school children. In 1990, 64 individuals died of measles, the highest number in two decades. The biggest cause of this measles epidemic was the failure to vaccinate children on time at 12 - 15 months of age. (North American Vaccine, Inc. 1996)

Immunizations for Children

It is important to recognize that all children must be immunized against 10 diseases. These are: Diphteria, tetanus, pertussis, polio, Haemophilus influenzae type b, measles, mumps, rubella, hepatitis B, and varicella. All but tetanus are contagious and can be transmitted from an infected person to an infected person.

For the benefit of the readers a brief definition of each disease follows:
Diphteria - 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 one out of 10 infected people;

Pertusis (whooping cough) - is highly contagious and causes severe coughing and occurs most frequently in children under five years;

Polio - cuses paralysis and is life threatening;

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

Mumps - causes fever, headache and inflamation of the salivary glands, three of every 10 infted people develop meningitis, an inflamation of the covering of the brain and spinal cord;

Rubella - or "German measles" - causes fever and rash, and causes severe birth defects when pregnant women are infected;

Haemophilus influenzae type b (Hib disease), which was contracted by one out of every 200 children before the age of five before vaccines were available, 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 the liver and liver cancer;

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

It is recomended that the migrant education staff person contact the nearest health clinic or family doctor to get the schedule for each type of vaccine. Schools may also require a child to have all vaccines taken and updated before the student is accepted in class. This researcher discovered that every state has different vaccination requirements. This condition opens the possibility of over-immunizing the child each time there is a move from one state to another. The other condition may

occur in which the child is under immunized and may require multiple vaccinations depending on the state. It appears that the lack of interstate coordination forces the migrant family to carry multiple vaccination cards which creates great confusion to all health staff.

Migrant Family Dental Needs

Research shows that dental disease in this country is, for the most part, a disease of poverty. In the state of Washington, 20% of the population has over 80% of the disease, and that 20% are migrant farm workers who traditionally seek health care in the public setting (Koday 1995). It should be noticed that the same conditions may be replicated all over the United States. Migrant families show similar economic conditions regardless of the state they work in Michigan should be no exception.

The immediate need for dental care and examinations is critical during the summer months. Dental care is very difficult to obtain because the majority of dentists are not established in the rural areas of the state. This forces the migrant families to travel long distances for care and may also require a dental health plan which they usually 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 must provide periodontal diagnosis on all patients and a full-mouth pocket charting and treatment as indicated. Charts should be considered in error if they don't have updated blood pressures and medical hustles.

Clinical quality standards must be based not on what the nurse or dentists feel is appropriate but on what the natural guidelines state are appropriate. Clinical circumstances must not dictate medical practice. It is understood that migrant, private or public dental clinics may not be able to provide every service to the patients needs or desire, but when it is provided, it must be the best quality.

Migrant Students 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 are special education and may require medical help move with their family and often lack special attention. Migrant children with dissabilities may not be encouraged to go to school because of the need for transportation as well as the amount of time parents are asked to remain in school for their evaluations.

Careful monitoring and reporting of all migrant special education children must be in place in order to serve the children that have immediate need for services. Lack of funds and their short time period in the school district must not be a valid reason for students to stay at home and not participate in the regular school program. Parents must request an evaluation and placement without waiting long periods of time. Regular school administration should make an effort to serve these students with the best possible staff person and not an interpreter with dubious Spanish language schooling.

Among the major barriers to migrant children with dissabilities for health care this author found that these are the top four causes:

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 an effort to assist the migrant child with dissabilities and provide the best possible services so that school continuity is not disrrupted. The following section provides the reader with some of the expectations of latino health professionals.

Expectations of Latino Health Professionals

Latino health professionals are expected to serve as translators for every person in the clinic. Many times the Latino health professional is obligated or their job is held hostage contingent upon serving as a translator for the same pay. It is not wise to misuse federal funds for transportation and translation services that are geared for medical assistance.

This is a common practice that must be addressed by health care and school administrators. Specific personnel must be hired to accomplish this task so that valuable health professional time is spent delivering health care and not translating. It would also be wise to coordinate with the local community centers and hospitals so that they can share resource people or volunteers to assit them with this great need.

Many schools, colleges and universities are already developing new programs in which they identify high school seniors or college freshmen to work with migrant families at the camps or clinics. These new models are not only encouraging migrant students to continue their studies but also are helping the administrator understand that migrants can also work in fields other than farming.

Medical Insurance and H.M.O.'s

Hispanics in Michigan have higher rates of unemployment and poverty than whites. It is expected that Hispanics will not have the opportunity to secure employer-funded health insurance or to purchase health insurance with their own earnings. Migrant farm workers in particular have no health insurance. Because of the nature of working by season and temporary, employer health care is not provided. Most of the migrants depend on the local community centers, migrant clinics and in difficult times, local "curanderos". Next, the author will present several HMO's 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 necessary medical care for Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) recipients and other low-income people who are under 21 pregnant, disabled, blind, or age 65 and older. Coverage includes hospital, nursing home, home heath and physician services; 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 and equipment; pharmacy and ambulance services; substance abuse services; and diabetes education.

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 Sate Family Assistance cases, recipients of State Disability Assistance who do not qualify for Medicaid, and other low income people. It is a limited program and does not include hospitalization. An average of 51,757 people were eligible each month.

The following section will include recommendations to State education agencies as it relates to health delivery systems that are successful.

Recommendations to State Education Agencies

The following are recomendations to state agencies so that they can improve the health delivery system to migrant families. These recommendations may be taken only as a guide. Each particular region should use the resources available based on their priorities to better serve migrant families. State agencies must concentrate on the mobile migrants first because they will have the most need of services.

Recommendations are as follows:
1. Set high quality standards for comprehensive school health programs. Provide technical assistance, resources, and coordination of services to local education agencies seeking to conduct comprehensive health education programs that are culturally appropriate and delivered in the language of the target audience.
2. Review state guidelines to ensure that local education agencies are responsible to the 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 designing and 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 mothers and fathers in their children's education, encouraging them to become partners with educators and to support their children's learning at home.
5. Enlist the help of schools of education in state universities to conduct top quality evaluations for health program improvements.
6. Work in coordination with migrant education and health programs in addressing all aspects of adolescent farm workers' health.
7. Request that colleges and universities develop programs to train and certify bilingual and bicultural health counselors recruited from the farm worker community.(U.S. Department of Labor report - Agricultural Workers Survey (NAWS) 1990: A demographic and Employment Profile of Perishable Crop Farm workers.)

The Ideal Health Care System

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

The system must provide:comprehensive health care services incorporating preventive care,

- health maintenance programs,
- health screenings,
- oral health clinics,
- mental health clinics,
- substance abuse prevention programs, and
- social services.

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

The system must be developed from the ground up, instituting services based on documented needs. Involvement of individuals, families, and communities is critical in the development of services for farm workers. It must maximize interagency coordination and integration of services to provide "one-stop" access to services. Such coordination and integration must offer universal access for farm workers, require minimal documentation for registration and reporting, and ensure interstate reciprocity as farm workers travel along the migrant stream.

The system must aggressively recruit multilingual, multi-cultural health care providers and other staff. Health care services should be provided by a multi-disciplinary team. In addition, the system must allow the allocation of work time for functions such as case management and practice-based research, rather than basing productivity ratings solely on numbers of patients.

The system must use a centralized, standardized database for collection of data on farm workers and trans-dental hygienists, and community outreach workers. Qualified staff may be hard to recruit in some areas.

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 a patient in the absence of a reasonably complete medical history. (Migrant Clinicians Network, Inc 1992)

System Characteristics

The ideal health care delivery system should make use of all types of marketing services to promote advocacy and community ownership. Examples of promotion activities include the use of camp health aides, community service announcements. Development of effective interagency collaboration requires a concentration of staff time. The system must foster such collaboration, must have both the staff and the organizational flexibility to work at interagency coordination. In addition, the system must provide funding to migrant health centers for outreach endeavors.

The system must be able to educate both the general public and Congress about the effectiveness of outreach in terms of improved health status and cost effectiveness. The system should continually seek new potential alliances for migrant health centers, including partnerships with growers and linkages with academic institutions. (Migrant Clinicians Network, 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 date rates, accident rates and other important information. It is a shame that the state of Michigan can count its birds better and more accurate that it can count its migrant families. Without this crucial information it is very difficult to recommend and implement changes necessary to plan budgets that will anticipate the immediate needs. Continuous research must be done to provide reliable migrant health information and to help prevent migrant student dropout and school discontinuity. Migrant student absenteesm is suspected to be highly correlated to health problems. The more we know about the childs health, the more we can plan and the less time migrant students and families have to wait in line to be served at a migrant clinic or hospital.

Transportation, access, culturally sensitive staff and language problems seems to be a factor that influences migrant health care. Research must include hard data that identify these and other problems which are present in our state.

As part of this paper the author is including a summary of immunization requirements for children attending Michigan child care programs and schools. Your primary health care physician may recommend a different schedule based on your specific needs. This is just 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 health care delivery systems ahead of time.

References

Be Aware! Common Cultural Practices and AIDS. Migrant Health Newsline, Vol. 4, No. 7, Dec. 1987, p.1.

Becerra, Jose E., Hogue J.R., Atrash H. K., Perez N., Infant Mortality Among Hispanics: A Portrait of Heterogeneity, (1988)

Binational Program, (1996) Ventura County Superintendent of Schools Office, 5189 Verdugo Way, Camarillo, California 93012.

Castex, Graciela M., (1994) Providing Services to Hispanic/Latino Populations: Profiles in Diversity, Social Work/Vol. 39, Number 3/May.

Centers for Disease Control. (1985). Tuberculosis and Migrant Farm Workers. Austin: National Migrant Referrall Project, June.

Commission on Civil Rights. (1977) The working and living conditions of mushroom workers. Washington, D.C.:US Government Printing Office.

Commission on Civil Rights. (1978). People who follow the crops. Washington, DC: US Government Printing Office.

Commission on Civil Rights(1983). Migrant workers on Maryland's eastern shore. Washington, DC:US Government Printing Office.

Duran N., (1995) Her Care for 'mis hijos' impresses U.S. officials, Muskegon Chronicle, Muskegon, Michigan, December 3.

Information Release on Viviremos / Se Pou Nou Viv/Learn To Live. National Coalition of Advocates for Students, Boston,MA, p.2.

Johnson, Nan E., Health Profiles of Michigan Populations of Color, Office of the State Registrar, Michigan Department of Public Health, 1995.

Mendoza F.S., et. al., (1991) Selected Measures of Health Status for Mexican-American, Mainland Puerto Rican, and Cuban-American Children, JAMA, January 9 -Vol 265, No.2.

Migrant Clinicians Network, McVea K., (1995) Self Injection Among North Carolina Migrant Farm workers,, Austin, Texas, March/April.

Migrant Health Newsline, Midney P., (1995) Produce Your Own Health Education Tapes, National Migrant Resource Program, Inc., Austin, Texas, Vol. 12, No. 3, May/June

National Migrant Reource Program, Inc., "Migrant Health Status: Profile of a Culture with Complex Health Problems", 1515 Capital of Texas Highway South, Suite 220, Austin, Texas 78746 (1996)

North American Vaccine Inc. (1996) "Why Immunize", Indian Creek Court, Beltsville, MD 20705

Ochoa Bogue H., et. al., (1993) Health Care Needs of Mexican Migrant Farm workers in Rural Illinois: An Exploratory Study, The Health Educator, Fall, p.27.

Ryan, R., Foulk, D., Lafferty, J., and Robertson, A. Health Knowledge and Practices of Georgia's Migrant Seasonal Workers Relative to AIDS: A Comparison of Two Groups. Georgia Southern College, Center for Rural Health, Sept. 1988, p.1.

Schmidt, Aurora Camacho, Cultivating Health: An Agenda for Adolescent Farm workers. National Coalition of Advocates for Students, 100 Boylston st., Suite 737, Boston, MA 02116. (1990).

Shotland, J. (1989). Full Fields, empty cupboards: The nutritional status of migrant farmworkers in America. Washington, DC: Public Voice for Food and Health Policy.

Stallsmith, Pamela (1996). " Migrants' lifestyle makes health centers busy places", Richmond Times - Dispatch, Sunday, November 10, Virginia.

U.S. Department of Labor report - (1990) Agricultural Workers Survey (NAWS) 1990: A demographic and Employment Profile of Perishable Crop Farm workers.

White-Means, S. (1991). The poverty status of migrant farmworkers. In Peter K.S. Chi, Shelley White-Means, & Janet McClain, Research on migrant farmworkers in New York State, 209-223. Ithaca, NY: State University of New York. ED 339 583.

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 influenzae 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.

Tome la Decision Correcta... Vacunelos!

ESTAS SON LAS VACUNAS QUE TODOS LOS NINOS 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 infuenza* 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) los niños a tiempo, para que sean protegidos contra las enfermedades de la infancia.

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
Educational Resources Information Center (ERIC)

REPRODUCTION RELEASE

(Specific Document)

I. DOCUMENT IDENTIFICATION:

Title: **The Health Condition of Migrant Farm Workers**

Author(s): Dr. EDGAR LEON

Corporate Source: MICHIGAN DEPARTMENT OF EDUCATION - MIGRANT EDUCATION PROGRAM
P.O. BOX 30008
LANSING, MI 48909

Publication Date: 1-1-97

II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, *Resources in Education* (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic/optical media, and sold through the ERIC Document Reproduction Service (EDRS) or other ERIC vendors. Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please CHECK ONE of the following two options and sign at the bottom of the page.

The sample sticker shown below will be affixed to all **Level 1** documents

The sample sticker shown below will be affixed to all **Level 2** documents

☒ Check here
For Level 1 Release:
Permitting reproduction in microfiche (4" x 6" film) or other ERIC archival media (e.g., electronic or optical) *and* paper copy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Level 1

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN OTHER THAN PAPER COPY HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Level 2

☐ Check here
For Level 2 Release:
Permitting reproduction in microfiche (4" x 6" film) or other ERIC archival media (e.g., electronic or optical), but *not* in paper copy.

Documents will be processed as indicated provided reproduction quality permits. If permission to reproduce is granted, but neither box is checked, documents will be processed at **Level 1**.

"I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche or electronic/optical media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries."

Sign here→ please

Signature: EDGAR LEON

Printed Name/Position/Title: EDGAR LEON

Organization/Address:

Telephone: 517 373 4582

FAX: 517 373 4589

E-Mail Address: eleon@msu.edu

Date: 4-1-97

RC020882

III. DOCUMENT AVAILABILITY INFORMATION (FROM NON-ERIC SOURCE):

If permission to reproduce is not granted to ERIC, *or*, if you wish ERIC to cite the availability of the document from another source, please provide the following information regarding the availability of the document. (ERIC will not announce a document unless it is publicly available, and a dependable source can be specified. Contributors should also be aware that ERIC selection criteria are significantly more stringent for documents that cannot be made available through EDRS.)

Publisher/Distributor:
Address:
Price:

IV. REFERRAL OF ERIC TO COPYRIGHT/REPRODUCTION RIGHTS HOLDER:

If the right to grant reproduction release is held by someone other than the addressee, please provide the appropriate name and address:

Name:
Address:

V. WHERE TO SEND THIS FORM:

Send this form to the following ERIC Clearinghouse:

ERIC/CRESS AT AEL
1031 QUARRIER STREET - 8TH FLOOR
P O BOX 1348
CHARLESTON WV 25325

phone: 800/624-9120

However, if solicited by the ERIC Facility, or if making an unsolicited contribution to ERIC, return this form (and the document being contributed) to:

ERIC Processing and Reference Facility
1100 West Street, 2d Floor
Laurel, Maryland 20707-3598

Telephone: 301-497-4080
Toll Free: 800-799-3742
FAX: 301-953-0263
e-mail: ericfac@inet.ed.gov
WWW: http://ericfac.piccard.csc.com