Agricultural Migrants and Public Health

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A COOPERATIVE inter-State and intra-State approach to migratory labor health problems was discussed by State health authorities during their Washington meetings November 4–7, 1953. At these meetings, the Association of State and Territorial Health Officers adopted the following resolution as recommended by its Special Health and Medical Services Committee:

"The Association encourages regional conferences . . . of health officers of States along major migratory streams to work out reciprocal programs for protection of the health of residents and migrants . . . to assure greater continuity and uniformity of services to migrants moving from State to State; and to share experiences on how localities and States go about meeting their problems. It is further recommended that each State and Territorial Health Officer examine the situation in his own jurisdiction and sponsor conferences with other State agencies concerned with the migratory problem."

In support of its recommendations, the Committee pointed out that "a large number of farm workers, many with families, migrate from State to State along fairly definite routes following the harvest of the major farm crops. Experience has shown that there is a high incidence of illness among these people and that there is a great variation in standards and services from State to State. The control of communicable disease and the meeting of the general health needs of groups of workers and their families at points along the routes would benefit from continuity and greater uniformity of services and procedures. It is believed that effectiveness of each individual State program would be increased by such a cooperative approach. It would tend to eliminate gaps and

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The following background information is based largely on the work of the committee, which has recently prepared a general overview statement of the current situation, including data from detailed national and State reports concerning the living and working conditions of farm migrants, their health situation and services, and recent recommendations by a variety of groups.

The health problems involved are varied and complex. An interchange of experiences among health agencies dealing with these problems would serve a useful purpose in the development of improved practices. The pages of Public Health Reports are open to papers and reports on this topic.

duplications. It would also tend to improve services and standards and reduce present wide variations from one locality and one State to another."

The Situation

More than a million farm workers and their dependents follow the crops each year, moving from State to State as well as within States to supplement the local labor force at critical periods of crop production (*3*). Migrants comprise only about 7 percent of the farm labor force. They are employed in significant numbers on only about 2 percent of the Nation's farms, but to the large-scale industrialized farm and to many smaller specialized farms their help is indispensable. Without them, crops in some areas could not be produced and harvested. At the present time, migrants help to meet peak season farm labor demands in local areas of nearly every State for at least a few weeks of each year. Even with increased farm mechanization and greater productivity per worker, it seems unlikely that the need for them will wholly disappear.

Farm migrants can be roughly divided into the following major groups, according to seasonal routes (*4*):

- Atlantic Coast—chiefly Negro families working in fruits and vegetables;
- Texas to the North Central and Mountain States—chiefly Spanish-American families working in sugar beets;
- Texas to Montana, North Dakota, and Canada—single men, or men who leave their families at home as they follow the wheat and small-grain harvest;
- Texas to California and the Mississippi Delta—Spanish-American families working in cotton;
- South Central to North Central States—Anglo-Saxon families working in fruits and vegetables;
- South Central States, Arizona, and southern California to northern California and other western States—Spanish-American, Negro, Indian, Anglo-Saxon, Oriental, and Filipino families working in fruits, vegetables, and cotton.

About half of the farm migrants are United States citizens. Most of the remainder are Mexican nationals. During 1952, nearly 200,000 Mexican farm workers came into the country temporarily under an international agreement between the United States and Mexico (*5*). Several times this number came into the United States illegally as "wetbacks," crossing the Rio Grande or elsewhere along the Mexican border without being detected (*5, 6*).

The aliens who enter the United States legally present a relatively minor problem. They are single males, screened for physical defects before entry. Unlike domestic migrants, they work under contracts which provide minimum guarantees regarding wages, housing, transportation, and protection against occupational disease and accident.

Wetbacks, on the other hand, enter the country without physical examination. They work without contractual protection and under constant threat of being apprehended and deported. They have no recourse if the wages paid are less than those offered, or if housing or other living and working conditions are below a minimum standard. The control of wetbacks is under the jurisdiction of immigration authorities, but the possible spread of disease by them is a public health concern.

Of still greater concern to health, education, and welfare agencies than the foreign migrants are the three-quarters of a million domestic workers and their dependents who comprise half of the farm migrant population. Citizenship entitles them to the rights and benefits enjoyed by other citizens. Too often their rights have been ignored because of local residence laws, shortages of local services, community disinterest or antagonism, and other reasons.

Many domestic migrants belong to a racial or national minority. Some are family farm workers or operators from marginal farming areas who become part of the farm migrant labor force for part of the year. Illiteracy or inability to speak and read English are common among them.

Working and Living Conditions

A single worker or worker with his family may travel only within one county or he may

travel more than a thousand miles and through a half-dozen or more States. In any case, the work on which he depends is so far from home that there is no chance to return each evening. "Home" may be only the one of his temporary residences in which he happens to spend several months of the year. It is unlikely to be home in the sense that it confers upon him and his family legal residence status. Nor is it home for a long enough time to enable the family to build for itself a permanent place in the community.

The professional or skilled worker who moves to look for a better job sooner or later becomes assimilated into his new community. But for the agricultural migrant, migrancy is a regular condition of his employment. He may never live long enough in a single community to share the rights and benefits available to other citizens. He is not a commuter, nor does he move from one community where he has been a permanent resident to another where there may be only a temporary dislocation during the process of assimilation.

The agricultural migrant belongs to a heterogeneous, widely dispersed group that cannot easily be organized to improve its situation. Wherever the migrant goes, he and his family are "outsiders." Their constant need for shifting from place to place makes it impossible for them to accumulate wealth or to build substantial housing. In addition to the fact that residence requirements bar him from qualifying for some community services, the migrant, himself, may lack interest or understanding, or he may be afraid to seek needed services, hesitating to disturb a possibly unfriendly community. Local residents at best may be indifferent and at worst, hostile, afraid that he and his family represent a hazard to the health, morals, and property of the established community.

Earnings

Like most other hired farm workers, he is not covered by minimum wage, workmen's compensation, unemployment compensation, and other protective legislation. He also lacks the health and welfare benefits made available to many industrial workers through collective bargaining.

Health and the Farm Migrant

". . . While some transients resemble, in their hygienic surroundings, residents of the same economic status, a greater proportion are forced to exist under almost every imaginable variety of insanitary condition . . . Serious overcrowding in the shelters is almost universal . . .

"Many camps not only have unsatisfactory facilities for sewage disposal but lack even a water supply that is fairly safe . . . A high rate of digestive diseases is normally found among persons living under such conditions.

"The effect of transients on community health is to increase the hazard of ill health to residents and to raise the incidence of most of the communicable diseases . . . This results chiefly from the fact that transients are not given equal consideration in community programs of sanitation, preventive medicine, and isolation of infectious cases of communicable disease."

These excerpts summarize the health situation of migrants according to a Public Health Service study covering 15 States in 1938 (1). The findings closely parallel those of a Colorado study in 1950 (2):

"Migrant families were large, averaging 5.7 persons.

"About half the families lived in one room.

"Only one-third could be sure their water supply was safe. For 13 percent it was obviously unsafe.

"Most families used 'pit toilets,' of which less than 1 in 4 would have passed elementary health inspection."

A Colorado physician remarked: "We know that communicable diseases are present among the migrants. The fatalistic acceptance of the situation, plus their poverty, makes the problem of medical care a critical one. Tuberculosis, enteritis, smallpox, typhoid fever, dysentery and venereal diseases have been more often detected by accident or search by public health officials than by patients voluntarily seeking medical assistance . . ."

The wages paid migrants may be relatively good—at least as high as those paid local workers at similar jobs. Annual earnings, however, are reduced by time lost from work as the result

of bad weather, poor crops, time consumed by travel from one place to another, and the problem of getting to the right place at the right time. Even with off-farm work to supplement work on farms, continuous employment throughout the year is unusual. It occurs only when workers have been able to piece together a number of jobs to make a long period of employment.

In 1949, less than 10 percent of the farm migrants in the United States had a full 250 days of work during the year. The remaining 90 percent averaged only 101 days per year. When both farm and nonfarm work are combined, earnings per worker averaged $514, excluding the earnings of children under 14. Annual family earnings are estimated at between $1,200 and $1,500 with two or more family members contributing to family income.

Average hourly earnings for all hired farm workers—including nonmigrants as well as migrants—have ranged from 24 to 44 percent of factory workers' earnings in recent years. Noncash perquisites—housing, garden space, and other items furnished by the farm operator—raise the annual cash earnings of regular hired farm workers by about 11 percent. For seasonal workers the value of noncash perquisites is only 7 percent of annual cash earnings.

Health, Housing, and Medical Care

Disabling illness rates for interstate family transients, according to the Public Health Service study in 1938 (*1*), were nearly twice those for residents of moderate or comfortable economic status and 1½ times the rates for residents of low economic status. Rates for epidemic and digestive diseases and for accidents were about twice as high among transient families as among residents.

Recent studies and reports confirm the findings of earlier studies indicating that the health level of migrants is below that of permanent residents of a community. Fresno County, Calif., prevalence of diarrheal disease among children observed in farm labor camps during July–December 1950 were significantly higher than for children observed in housing projects and at child health conferences (*7, 8*).

The infant mortality rate among Colorado migrants was nearly twice that for the State according to the 1950 study (*2*). More than a third of births to migrants in the 5 years 1946–50 were not attended by a physician. Only 42 percent of the persons surveyed had had smallpox vaccination. Only 10 to 20 percent had had diphtheria, whooping cough, or tetanus immunization.

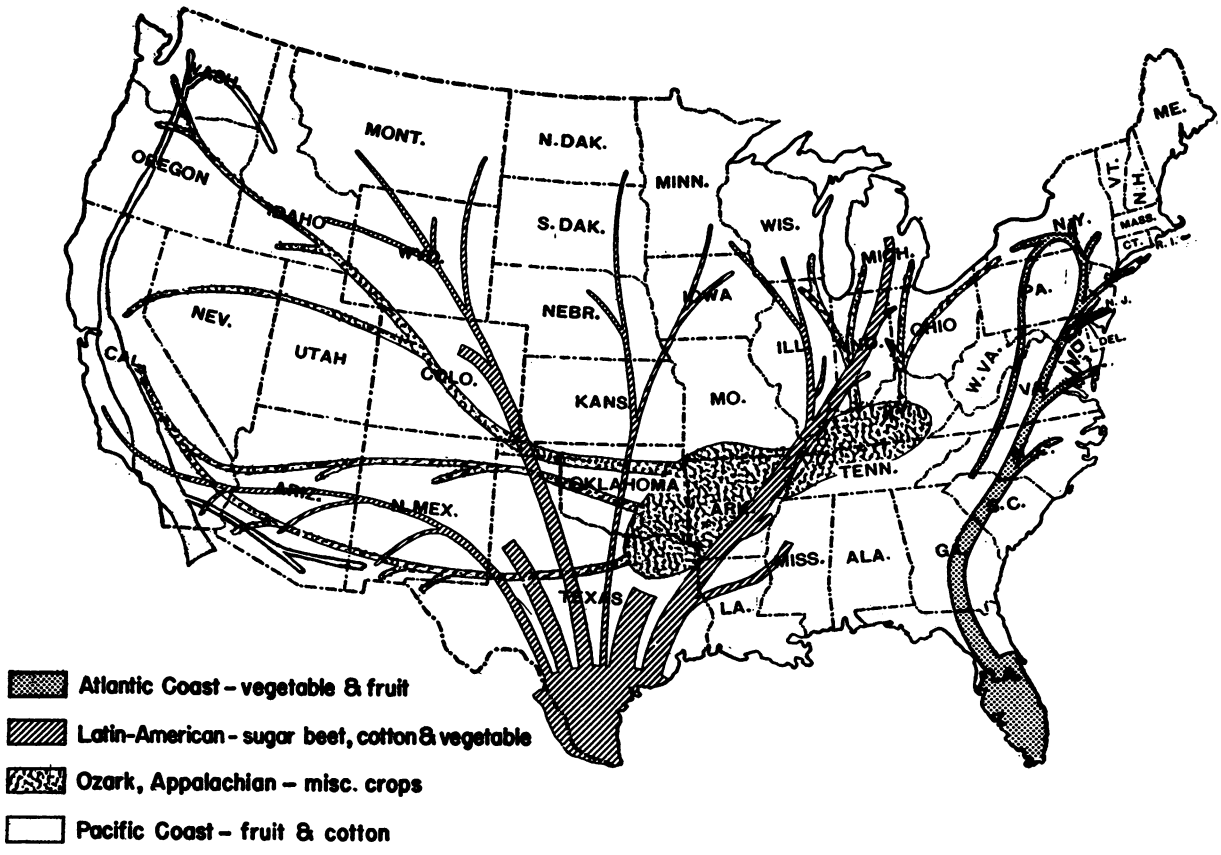
Nutritional deficiencies are common. The diets of migratory families are affected by low income and by lack of adequate cooking facilities, facilities for food storage, or time for food preparation, as well as by lack of understanding of nutrition requirements. A physician testifying before the President's Commission on Migratory Labor in 1950 reported dietary deficiency diseases such as pellagra among migrant workers as well as "ordinary starvation" (*6*). The Colorado study (*2*) commented on the "poverty diet" of the families surveyed in 1950.

Housing and Work Hazards

A number of States have laws or regulations which apply to all labor camps or to migrant camps specifically. In some, enforcement is not adequate. In other States, laws and regulations are lacking. According to a labor department official in one State: ". . . we have migrant workers living . . . in tents with no floors, on canal banks without any proper sanitation . . ." (*6*). A health officer in another stated: "Workers . . . crowd into shacks, tents, trailers, and similar quarters. Adequate and safe water supplies, toilets, bathing facilities, and proper sewage and refuse disposal are seldom provided . . ." (*6*).

However, some employers insist that poor housing conditions are not always their fault, and that housing which meets an approved standard is sometimes misused by the workers who occupy it.

The living conditions of migratory workers frequently lead to recurrent digestive disturbances and to the spread of respiratory and other infections. In addition, the migrant shares with other farm workers exposure to the occupational risks of agricultural employment—accidents, chemical poisonings, skin disorders



Source: U. S. Department of Labor, Bureau of Labor Standards.

Travel patterns of seasonal migratory agricultural workers. The map shows the northward migratory movement. This is reversed as the crop season ends in the northern States and the workers drift back to home base—for many of them, southern California, Texas, and Florida.

from working with citrus fruit, and other hazards (*9*).

Medical Care

Except in extreme emergency, migrants are usually without regular medical services. An employer sometimes assumes responsibility for medical care for his workers. In rare cases workers are covered by insurance. Emergency hospitalization is sometimes financed by local welfare departments.

The 1938 study (*1*) reported: "The data presented on the cost of public hospitalization now being supplied to transients in general hospitals seem to show that an enormous load from this cause is being carried by some communities, in spite of the fact that transients generally receive considerably less medical care and hospitalization than do residents."

In 1950 one Colorado county spent nearly $5,000 for hospital care for 19 migrant families. Another reported spending $65,000 for tuberculosis patients during the previous 5 years. Between 50 and 60 percent of the patients were from "the substandard slum type of housing in which Spanish-American agricultural workers live." In no other Colorado county was comparable assistance to migrants reported (*2*).

The combination of poor diet, poor living conditions, and lack of medical care tends to aggravate any disability a migrant may have. This fact was commented upon in 1938: "Living in a camp . . . and other temporary quarters, lacking even facilities for self-medication or continuous rest in a comfortable bed, a disabled transient who cannot secure medical attention not only is subjected to a more miserable experience than is a resident ill of the same condition but he is also much more likely to have serious complications . . ." (*1*).

A handicap that is likely to affect the migrant more acutely, although shared with other rural residents, is the lack of physicians, nurses, and other health personnel in rural areas compared with urban places.

The interrelatedness of health, education, and welfare problems of migrants is illustrated by recent statements of State school officers (*10*). When asked the reasons migrant children were not in school, they often referred to problems of health—either real or based on suspicions of the community that the migrant child might be a disease carrier as the result of his living conditions.

Governmental Responsibilities

Responsibility for eliminating the problems which arise because of migrant labor and meeting the needs of the migrants is widely diffused through national, State, and local governments and agencies. In the Federal Government, for example, the Department of Justice, through its Immigration and Naturalization Service, is responsible for control of wetbacks. The Departments of Justice and Labor share responsibility for the legal importation of Mexican workers, with the Public Health Service assuming responsibility for health examinations. Other responsibilities of the Department of Labor include aiding "workers to find jobs and employers to find workers," and enforcing the Federal child labor law. The Department recognizes child labor in agriculture as a major problem in enforcement of this law.

The Bureau of Indian Affairs in the Department of the Interior has a concern for migrants to the extent that reservation Indians become part of the migratory labor force for part of each year. The Department of Agriculture makes studies of farm migrants as part of its investigations of the farm population and farm manpower. In some cases its educational services are extended to migrants through the Agricultural Extension Service.

The Department of Health, Education, and Welfare has varied responsibilities under programs to serve all eligible persons, in some cases the entire community. Such programs include those of the Children's Bureau, the Office of Education, the Bureau of Public Assistance, the Office of Vocational Rehabilitation, and the Public Health Service.

This résumé of Federal responsibility is, of course, incomplete, but it serves to illustrate the scattering of interest and concern for the welfare of migrants that is generally found in State and local governments and among voluntary agencies as well. With few exceptions, programs are designed to serve a permanent community and are ineffective in reaching migrants. Many of the reasons for their ineffectiveness have already been referred to—residence requirements; inadequate facilities, staff, and funds; language barriers; generally inadequate means for informing migrants of the services available or for informing agencies of migrants' needs; and other obstacles. Moreover, programs designed for a fixed population often must be modified to meet the needs of a population "on the move."

A further problem for the migrant in obtaining community services is the attitude of residents in many areas, which is usually reflected at least in some degree by local official and voluntary groups. Although he may be greatly needed by the community for its own economic welfare, he is unlikely to be accepted as part of the community while he is there. Near the Mexican border local residents may shrug off responsibility, looking at the shacks across the border and saying of their own Spanish-Americans, "They never had it so good in Mexico." And in States farther north people may say, "These people live in shacks and hovels in Mexico and Texas. Why should we improve their conditions here?"

Local and State Programs

Where such attitudes do not exist or have been largely overcome, significant changes have occurred. Hollandale, Minn., for example—a community of less than 400—has a continuing program to get the children of 800 migrant families into schools while they are in the area. The Waupun, Wis., Community Council on Human Relations has tried to integrate the migrant workers into the community by holding "family nights" for both migrants and local residents and by welcoming the migrants into local churches.

The New York State Department of Labor requires anyone bringing in 10 or more migrants from outside the State to register. Under this requirement, 820 migrant camp properties came under health department supervision during 1952. An average of 8.2 inspections were made for each property under supervision and many improvements were reported.

New York's Interdepartmental Committee on Farm and Food Processing Labor involves 9 State agencies in efforts to plan and work together. As part of this coordinated effort, the State health department participates in providing nursing services for migrant families, supplementing local services as necessary by supplying nurses from the State staff. Before the peak season in an area, conferences are held by the public health nurses, their supervisors, and camp operators and owners to review the services available, make an estimate of expected health needs of the migrants coming in, and plan to meet these needs.

State and local programs in other areas also provide needed services for migrants. Taken altogether, however, these programs are few and scattered, important chiefly as local demonstrations. Local officials trying to stretch services to meet the needs of migrants comment: "We can't do a 12-months' job in the short time the migrants are here." How to provide continuity of services as families move from place to place is a question they feel demands solution.

Reports from Palm Beach County, Fla., illustrate the problems involved in some of the local efforts. In one labor camp in the county, school enrollment ranged from 88 in September to 314 in May. In all white schools of the county exclusive of those in the main population center, enrollment increased by more than 2,000. The increase in the Negro schools was a little less than 2,000. If all children had been required to attend, the limited classrooms could not have held them.

The Palm Beach County Health Department finds it equally difficult to meet the needs of 20,000 workers and their families coming in each year. The efforts they make may be at the expense of programs for permanent residents. And the same migrants with the same problems are likely to be back on their doorstep year after year with little evidence that they have had care while they traveled in other States.

Recommendations by Various Groups

For the last half century, local, State, and national groups have been concerned about ways to improve the living and working conditions of migrants. Recurring recommendations of various commissions and conferences give evidence of this concern. The Country Life Commission in 1909 recommended employment on an annual basis and good housing. The Tolan Committee report in 1941 recognized the need for States of heavy in-migration to adopt laws establishing minimum conditions of health, sanitation, and housing on farms employing migratory agricultural labor (*11*), and so on, to the Federal Interagency Committee on Migratory Labor's report in 1947 (*12*), the report of the President's Commission on Migratory Labor published in 1951 (*3*), and the hearings on migratory labor in 1952 (*6*).

Out of the deliberations of such groups certain general principles and recommendations have evolved:

1. A program for migrants should be developed in terms of meeting their needs as human beings—not just to meet an emergency.
2. The health problems of migrants involve need for protecting the communities where they work temporarily as well as for protecting the migrants themselves.
3. The eventual goal should be to give as many migrants as possible roots in a local community where they can make their own place, gain community acceptance, and become eligible for the rights and benefits available to other citizens.
4. Services for migrants should be developed in a way that will integrate them into rather than separate them from the rest of the population.

Services must be adapted to the special needs of migrants, however, with recognition of their differences from local community residents in background, attitude, and behavior; with estab-

lishment of stationary services at major points of labor concentration and mobile services as needed; and with arrangements for continuity of services as migrants travel from one place to another.

Special measures should not be set up to meet a need that can be met through an existing program. The interest and activities of local, State, and interstate official and voluntary agencies should be encouraged and built upon as fully as possible.

5. Existing housing, health, and other standards, and laws and regulations applicable to migrants need to be applied to their situation; if necessary, these should be modified to assure the migrant the same protection and benefits available to other citizens.

6. Methods need to be developed whereby health services of high quality—both preventive and curative—can be distributed effectively and economically throughout rural United States.

Summary

Peaks of demand for agricultural workers create peaks of need for health services in many communities in many States. Some of these communities do not have public health and medical care facilities and personnel sufficient to meet their own needs, and even those which are well supplied have difficulty in meeting the greatly increased needs presented by migrant workers and their families for a few weeks or months each year. Also complicating the problem of matching needs with services in many situations are such facts as nonacceptance of these families by the community, ineligibility of nonresidents for services of various types, and ignorance of migrants as to where to seek help.

Migrants present the gamut of needs for health, education, and welfare services—needs which are intensified by their economic and educational status and by the fact of their migrancy. Challenges to official and voluntary agencies lie in finding ways to coordinate required services locally and to make these services continuous as migrants move from place to place. Some States have made considerable progress in meeting the first of these challenges. Interstate cooperation will be required to meet the second. At stake are the health and welfare of more than a million people who make a vital contribution to our national economy as well as the health and welfare of the communities through which they move.

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