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Migrant Farm Communities: Culture, Education, Nutrition And Health Consequences

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Disciplines

Anthropology

MIGRANT FARM COMMUNITIES: CULTURE, EDUCATION,
NUTRITION AND HEALTH CONSEQUENCES

By

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Abstract:

This study researches the healthcare disparities in migrant farm workers of NJ following a series of field observations within the local clinics and community settings of Hammonton , NJ. Through preliminary readings and research on past studies of the local migrant communities in NJ, specific health issues emerge which are unique within migrant groups, unseen in Mexicans who do not migrate, yet seldom noted in those who immigrate to the U.S. permanently. Cultural and language barriers present themselves within the recent health and education initiatives in this area of study. The link between the cultural and language barriers which exist and the healthcare disparities which result is a very complex set of processes, which require further study, in order to more specifically target the elements in need of change with regard to the existing health and education initiatives for migrant communities. Migrant farm workers represent a unique set of cultural variables within a home which is not actually their home, living among people in a community, in which they are not really a part, resulting in marginalization and isolation which fuels doubt and distrust in the systems in place, resulting in health disparities. Language and cultural barriers prevent otherwise reasonable health initiatives from success in migrant communities, mainly from misunderstandings by both the migrants and the healthcare workers.

I. Introduction

Within migrant farm communities, there exists a great amount of health disparity in relation to the marginalization which is experienced every day by these individuals. Although healthcare is accessible, affordable, and in many cases free to migrant farm workers and their families, many never take advantage of these benefits. Though the reasons vary between individuals, the consequences remain constant: individual health declines and becomes a burden on the worker, their immediate community, the farm owner, and the community at large. Therefore, it is essential that the need for proper health education and screenings is understood by the migrant communities, as well as efficiently administered by the healthcare system. Prevention is the key factor in the effort to curtail and eventually eliminate high amounts of preventable disease progression in the migrant community. However, a deep understanding of the factors that stand as the foundation for the current belief system is necessary before an appropriate plan will prove effective in this complex situation. Marginalization is the main factor which eliminates this population from receiving and adhering to health guidelines, placing them at an increased risk of resulting health disparities.

When considering the relationship between health and status in society, it is appropriate to evaluate the social position of the group within the broader society in which they live. Since migrants live predominantly within the confines of their own migrant community, yet within the larger one surrounding theirs, marginalization and stigmatization occur. Essentially, migrants are a society within a society, living just on the fringe of that community. They are present, yet their presence is unwelcome. Their camps are well hidden behind large farming areas or in heavily wooded areas. Society wants to see them in the fields, but wishes to see them nowhere else. They are invited to work in the U.S., yet denied many basic human rights, residing in living conditions

that most would find deplorable. Migrants are seen, yet unseen, needed, but unwanted, living on the margin of acceptability. The migrants are not privy to the basic rights that most Americans take for granted and would fight bitterly to maintain. The civil rights in America which have been extended to include all races, genders and creeds, do not apply to them in many cases. They are marginalized, stigmatized, excluded, targeted and often blamed for things out of their control. They have no voice in their community, few rights in society, and must live every day with the threat of being returned to their country of origin. There are few who advocate on their behalf, most of society ignorant of their status in the U.S., unwilling to reconcile their prejudices with the fact that migrants are productive members of their society.

This thesis studies migrant farm workers focusing on patterns of healthcare which lead to healthcare disparities, and eventually lead to health disparities of migrant farm workers of NJ, incorporating a series of field observations within the local clinics and community settings of Hammonton, NJ. Through preliminary readings and research on past studies of the local migrant communities in NJ, specific health issues emerge which are unique within migrant groups, unseen in Mexicans who do not migrate, yet seldom noted in those who immigrate to the U.S. permanently. Hypertension and diabetes co-exist in populations of relatively young, active migrant men, in contrast to the general American population where young, active men generally are at a lower health risk for these diseases. While poor diet is a major factor in these processes, marginalization plays a large role in the development and early onset of these factors, as well. While one cannot ignore the tendency of these individuals to consume a diet rich in simple sugars and saturated fats, the consumption of prepared and processed foods, fast foods, and junk foods is intricately entangled within their marginal status. Factors such as poor living conditions, *barrio* style housing and a lack of adequate kitchen facilities in many migrant camps leads to the

over-consumption of “empty calorie” foods. A lack of knowledge about the importance of healthcare married to the machismo culture in most of the migrants produces an attitude of apathy and sometimes even contempt for the healthcare system. Even in areas where free health screenings exist, often migrants avoid the process for personal reasons. Some of the younger men, who feel that they are young and healthy, assume that the health checks are unnecessary. Many of the older men understand that they have health issues, but in an effort to avoid a “label”, they avoid the checks. The reasons are fairly complicated, including but not limited to the fear of deportation, avoidance of any stigma related to a diagnosis, paranoia about possible unemployment, or unwillingness to remain accountable to a healthcare worker or physician. Cultural and language barriers present themselves within the recent health and education initiatives in this area of study. Although healthcare workers are required to speak Spanish, due to the high variability in country of origin, many dialects and cultures exist, even within the same camp, causing misunderstandings between the healthcare workers and the migrants. The link between the cultural and language barriers which exist and the health disparities which result is a very complex set of processes, which require further study, in order to more specifically target the elements in need of change with regard to the existing health and education initiatives for migrant communities. This study acts as an informant on the existing system and current relations between the migrant communities and healthcare workers, in order to have a baseline to act as a catalyst for further change.

II. Background Information

The United States is a nation with a history rich in diversity, beginning with the first Americans who crossed the Bering land bridge into the Pacific Northwest and continuing into the modern immigrations from Asia and Latin America. Throughout this time span, people of many cultures have immigrated into the United States, stimulating cross-cultural interaction. Many groups have come to the United States seeking religious, political or social freedoms. The first European immigrants from England set out to achieve such freedoms, creating settlements in the Chesapeake area of Virginia. Shortly after, the English Pilgrims established settlements in New England to achieve religious freedoms. Soon after, the Dutch Quakers and German Amish settled in Pennsylvania and New York; the Scottish and Irish began to settle in Appalachia; finally, the Swedish and Finnish settlements were established on the frontiers. It had become a pattern that religious freedom seekers flocked to the U.S. for such an opportunity. At times, however, certain immigrating groups have been the target of prejudice, unfair stereotypes and ridicule, causing them to become stigmatized, marginalized and isolated. During the same time period in which so many groups were arriving to pursue religious liberties, Africans were being taken into slavery, shipped here to be bought and sold as property to plantation owners. The same freedoms being sought out by these immigrants would soon be denied to others who did not share their religious views or beliefs. Jews in Philadelphia, dubbed the city of brotherly love, were unable to bury their dead in cemeteries within city limits: they were unworthy of this privilege. Throughout the several hundred years between the birth of our nation and the present, we have seen a great influx of Hispanic and French speaking settlers in the southern U.S. and the Southwestern U.S. First Florida received a large number of Spanish immigrants during the time of Saint Augustine and the colonization of the New World, while Louisiana received French immigrants, creating a Creole culture. Later French speaking immigrants from Quebec arrived in New England and

New York, and Mexican immigrants started to move to the Southwest. These cultures have mixed with and created new cultures in these border areas of the country. In modern times, Mexican immigrants outnumber any other immigrant group coming into the U.S. Since 1980, there is no other immigrant group as plentiful as the Mexican immigrants arriving in the U.S. (See Appendix A) Due to many factors, including the labeling of Mexico as a third-world country, the status of most of the Mexican immigrants as low-income laborers and the Spanish/English language barrier, Mexican immigrants continue to be highly marginalized.

As a large part of the immigrant population, migrant workers play a key role in the dynamics which exist within these populations of modern day immigrants. The U.S. invites and employs many of their agricultural work-force from outside of U.S. borders. There are various types of migrant workers in the U.S., some have legal resident status or even citizenship in the U.S, while most are in the U.S. on a temporary visa. The majority of farm workers have minority status, with three of every four workers of Mexican descent. The demand for low-cost labor in a struggling agricultural industry has increased greatly in the recent past. Most farm owners are hiring the majority of their new workers from foreign countries. In addition to Mexico, workers come here from Puerto Rico and Cuba, Jamaica and Haiti, Central and South America, Thailand and Laos, with others from Native American or African American descent. Most farm workers speak little to no English, travel independently of their families, have poor living standards, little access to nutritious foods and remain highly marginalized in American society. Although most migrants are in the U.S. legally, society stigmatizes them as a group of illegal immigrants, undeserving of services or healthcare. The H-2A program set up by the U.S. Department of State grants temporary guest worker visas to seasonal workers, but fails to acknowledge or intervene in the problems of poor wages and bad working environment which this type of program creates.



Migrant farm worker camps are poorly built, badly maintained, often sub-standard type structures, which would not be considered an appropriate living facility by even the most humble American standards. Most are over-crowded, with little access to adequate washing or cooking facilities. They are well-hidden groups of shed-like structures or sometimes trailers located adjacent to the main farms, but usually well-disguised behind other farm buildings or in heavily wooded areas. In addition, some farm owners frown upon migrant workers reporting or receiving treatment for injury or illness. These farm owners often take possession of the workers' visas, preventing them from relocating to another camp. Those who find themselves in these conditions are only degrees from what most would consider as full enslavement.

The main difference between migrant workers and successful immigrants exists in support networks and incorporation into the larger society. Migrants have little to no family traveling with them, causing them to send most of their earnings back to their family in their home country. This leaves them with no constant support network, as they generally travel every few weeks to whichever areas have need of them, leaving any friends they have made in one camp to take a job in another area. Most workers do not travel with their families, unless they are of foreman status, those who are in charge of large camps and are also contractors of other

workers from their country of origin. They have little access to adequate healthcare, proper nutrition or decent living facilities. This leaves them with little personal investment in their camp, the farms or on a larger scale the community or American society itself. Successful immigrants, on the other hand, take part in the community, have a support network including their families, have a voice in society and contribute to and receive the benefits of living in a community.



Photo/ David Smith



Photo/Charlotte Raymond of Bristol-Myers Squibb Company



Photo/Charlotte Raymond of Bristol-Myers Squibb Company

III. Methods/ procedures

After presenting my research proposal to the Outreach Coordinator at Southern Jersey Family Medical Center, I received permission to do several months of participant observations as an outreach volunteer. After thorough research of pertinent literature, I

utilized a combination of observations and interviews in the migrant farm community of Hammonton, NJ. I worked very closely as an outreach volunteer in many of the local migrant camps of Hammonton, visiting two to three camps each week for a series of twelve weeks. Through conversations and healthcare assessment interviews, I was able to relate certain patterns to the literature reviewed and observe trends in marginalization, living conditions and healthcare disparities.

IV. Marginalization: Living on the Fringe of Society

Ask anyone in the area of Hammonton if they know any migrant farm workers, and you will likely receive a response similar to the following discussion with a new friend in my community when we first re-located to the Hammonton area several years ago.

Me: “Do you know any migrant farm workers? Maybe your children have some friends from school whose families are migrants.”

Anne: “No not really. I mean some of them go to my daughter’s school, but she isn’t friends with any of them really. Right, Mary?”

Mary (Anne’s daughter): “Oh, we see them at school, but nobody actually talks to them. They keep to themselves and they aren’t really part of the school. No, I guess we don’t really know them...just that they go to our school.”

Or, when I asked a local landscaper if the Mexicans he hires were migrant workers before they worked for him...

Bob: “I have no idea. They show up looking for work and I bring them out to a job. If they stay and work all day every day, I pay them at the end of the week. Why the interest in the migrants?”

Me: “Well, it intrigues me that we have an entire people living among us that nobody seems to care for or even know about. Do you ever think that maybe we should help them more with the transition into American society? Don’t you think they should have decent living conditions and access to healthcare?”

Bob: “Who is ever going to pay for that? They aren’t Americans. If they get sick, they should just go home and then we send for more workers!”

Encounters such as these with local people in the community has become a normal occurrence for me in the last few years, and it has served to act as a catalyst for the initial perusal of literature on migrant health and education. In searching for information on migrant health workers’ isolation, Kari Bail’s research on the health effects of the invisibility of migrant workers in Georgia furthered the need for a deeper study into marginalization and isolation. Bail explains one of the encounters between a nurse, Jackie, and a local minister in Georgia, which was retold to her while doing case studies:

“...there is one church that we [Farmworker Family Migrant Health Project volunteers] go to for lunch and when we first started going there, the minister at that church... told the group of nurses that the first time we went to lunch there that he didn’t know there were migrant farm workers here, and see, they are oblivious to them. They ride right by them. I guarantee if we stopped at any house up there and said, “I am looking for a farm

labor camp close by here? Do you know where it is?” They wouldn’t know this was here. They wouldn’t know this was here.” (Bail)

In considering the mysterious migrant worker, curiosity formed the question, “why are these people so invisible, living in our community yet not part of this community, seen in the fields but barely noticeable elsewhere?”

Migrant farm workers in the Hammonton area live among the community year round, numbering thousands during “high season” in the summer months, with only a skeleton crew averaging around 6 contractors residing in each camp during the winter months. Most of those who remain through the winter months are the oldest, most trusted migrants who have a more permanent status in the U.S. These are the lead workers responsible for contracting the high numbers of temporary guest workers during the summer months. Due to the nature of the *H-2 guest worker visa* program in the U.S. the only contractors who are both permitted and invited to bring their families with them are those with more permanent status in the U.S. The *H-2* program only allows individual workers to contract temporarily with specific employers for temporary work each season. The farm owner must supply the workers with housing but are not required nor allowed to accommodate their families in the camps.(Bauer) The lead workers however, are often allowed to bring their families and are given small trailers to accommodate their needs and encourage them to continue working with the farm owner. The workers pay no additional housing costs, making it very appealing to them to keep their positions at the farm. However, this further limits their interaction in the community, isolating them from the social benefits of living in the town.

Housing in the migrant camps is well hidden from view of the community, generally off the main roads, behind the visible frontage of the farms, often concealed in highly wooded areas, accessible only by narrow dirt roads. The housing facilities are generally large shed style or pole barn structures with no insulation, metal or plywood walls and concrete floors. The cooking and washing facilities are often completely separate from the sleeping quarters, accessible by separate outdoor entries. Most camps provide a central cooking facility comprised of one stove, oven and refrigerator, located in a small room or building with a very limited amount of seating. Although adequate in the winter months, these facilities are unable to supply food to the high numbers of workers in the summer, resulting in the consumption of large amounts of fast food, junk food and highly processed or pre-packaged items from local quick marts. The washing facilities are equally as small. Several sinks, toilets and washing machines per camp suffice in the winter months. However, consider that the numbers often rise from an average of 6 contractors to over 1,000 temporary workers in one camp in just a few months. These facilities change from meager to unacceptable overnight. In most cases, the community doesn't ever see or realize these squalid conditions. This hidden population remains concealed out of sight and out of mind, seen only as a labor force in the fields, never as a part of society.

Initially, the migrant workers appear to be in good physical health: strong, active and healthy. However, once health screenings are performed the deficits in their living conditions, their underlying nutrition and inadequate access to proper healthcare become obvious. The Migrant Health and Nutrition Outreach division of Southern Jersey Family Medical Centers is responsible for the health initiatives within the migrant camps of the greater Hammonton area as a whole. Year round access to quality, affordable healthcare is made available, with free routine health checks in each camp. Blood pressure and sugar checks are offered most frequently, and

nutrition education is presented in Spanish at the camps by the outreach staff and volunteers. For anyone in need of follow-up, routine physical exams, vision or dental check-ups, the outreach specialists encourage office visits at the health center, particularly during the winter months. In many cases, blood pressures are alarmingly high, which is particularly concerning in young active workers in their early twenties. In some cases, they have a family history of hypertension and have previous knowledge that their blood pressure is elevated. However, in many situations, they are completely unaware and caught off guard when they hear this for the first time. Blood sugar tends to be very high in older migrants, who often have numbers equivalent to an uncontrolled diabetic high blood sugar. Some of them admit that they should be on medicine and they do not take it regularly. Many migrants are smokers, eat a diet high in salt and sugar, and although they are working in the fields all day, do not stay well-hydrated with water, often choosing alcoholic beverages instead. It is not unusual to arrive in the camps around dinnertime and find several of the workers already inebriated. At one camp not long ago, one migrant worker joked with an outreach worker who was conducting blood sugar screenings. When she asked to perform a finger prick for the sugar test, he told her that she wouldn't get blood from him; it would be beer. Life in the migrant camps is hard, with fourteen hour work days common in the summer months. No family support network, little time to access the healthcare system, and poor working and living conditions take their toll on the workers. The little spare time they have is spent enjoying fast food, cigarettes, alcohol, and *telenovelas*. The importance of proper nutrition, adequate water and appropriate healthcare can seem like a punishment. Considering the isolation which exists, their state of mind can be quite vulnerable. Removing the few pleasures which they enjoy can make the difference between as normal of an existence as can be expected and the onset of depression or anxiety. The mental health implications which stem from

marginalization can be vast and related to many factors including their extremely limited mobility within the U.S., the threat of deportation if they don't meet the expectations of the farm owner and their previous failure to succeed in their home country.(Rehm) The results of depression or anxiety over these issues can often result in unrealistic idealistic goals, such as the expectation of working fourteen hour days, seven days a week without any breaks and never falling ill or needing medical treatment. Often fear-based behaviors develop from these worries, giving way to more stress and eventually fatigue and illness result. A proper balance between all of these factors is difficult to accomplish under the circumstances in which they find themselves. However, with the help of an existing support network, these conditions can get better. Therefore, maintaining good relations between the healthcare workers and the more permanent workers in the migrant camps is essential throughout the winter season, in order to foster a more positive environment during the busy summer months.

Migrant workers are a separate society of individuals without the same equality that streamline America enjoys. In most cases the workers must remain on the farms in which they are employed, because they are contracted by employers who require their services from before sunrise to after sundown, seven days a week. Since many farm owners retain the guest workers' H-2 visas in their possession, it prohibits the workers from leaving the grounds and traveling into the surrounding community for fear of deportation. (Bauer) If they are found without their papers, they worry that they will be considered illegal immigrants and sent to their presumed country of origin. Regardless of which region in Mexico they are from, they run the risk of being sent to an arbitrary location in Mexico, where they must then find their way home. In addition, they are often considered to be from Mexico, while many of the workers come from other countries, such as Guatemala or Honduras. While each individual is provided housing and

limited access to food at no cost, each individual incurs the cost of visas and transportation from their home country, across the U.S. border and finally to the destination farm where they have been contracted. Therefore, they arrive on the farm indebted to the farm owner, which apparently is seen as a reason they must relinquish their documents until they work to sufficiently pay their debt. They must pay this debt before they can profit from the work and send money home to their families. However, even after they have paid back what they owe, often the farm owners retain their documents, as a means of keeping the migrants on their farm to ensure that the entire crop is harvested. In this way, the migrants bare a close resemblance to indentured servants of the colonial era, but without the opportunity to acquire any ownership of the land as was afforded to the colonial servants. “Former House Ways and Means Committee Chairman Charles Rangel put it this way:

‘This guestworker program’s the closest thing I’ve ever seen to slavery.’” (Bauer)

V. Stigmatization: undeserving, unhealthy, or unproductive?

The dehumanization of this people group has much further reaching influence than appears on paper in the description of the H-2 guest worker program. In their attempt to rise above their means and make a better life for themselves and their families, arises the issue of stigmatization. Individuals will go to great extremes to avoid the stigma of being unhealthy or unproductive. They are willing to work longer and harder than most Americans would allow for their labor animals. Seemingly, migrants are an expendable labor force which, if not performing at optimal efficiency, will be returned to their country in exchange for other laborers. There have been cases of immigrants and migrants being returned to an arbitrary region of their presumed country of origin due to the extreme cost of medical treatment for an illness or disease considered too

expensive to treat.(Sontag) This perpetuates a fear of deportation in relation to medical treatment. This status as a sort of commodity also de-values the individual in their own mind, as well as in the way others view them. They already feel stigmatized due to the inability to perform and succeed in their home country.(Rehm) Therefore, the pressure to do so in the U.S. is that much greater, effectively creating unrealistic expectations and pressures. Failure to meet these goals results in the stigma and label of “unhealthy” which implies “unproductive”. For this reason, many migrants will avoid seeking medical treatment, even when healthcare is accessible.(NCFH) In essence, their plight limits the access to proper healthcare even when it is logistically possible, affordable and encouraged by the healthcare workers. Paul Farmer has put forth the question, “If access to health care is considered a human right, who is considered human enough to have that right?” In his view “looking back over the concept of human rights, we can see that social inequalities have always been used to deny some people status as fully human.” (444)

On several occasions, while visiting local camps in Hammonton, specific individuals who were supposed to be contacted for follow-up on a certain matter would seemingly disappear upon the healthcare team’s arrival. The explanation to their whereabouts was always vague, the presumption of the Outreach Leader most often that they were hiding. When questioned as to why they would hide from healthcare workers performing free repeat screenings for prior health concerns, the reply was that they sometimes feel that the original screening must have been in error, that they are young and healthy and don’t want to be labeled as sick. These individuals are essentially foregoing their right to healthcare in an effort to avoid the stigma associated with being sick. In this way they are contributing to their own de-humanization.

VI. Language Barrier and Illiteracy

Issues of regional dialect and indigenous languages often present themselves within migrant communities. If the healthcare workers are to encourage and promote health and wellness within the camps, it is essential that they are able to effectively communicate with the migrant workers in their native language whenever possible. Although no English is spoken between the outreach specialists and the migrants in Hammonton, Spanish is generally assumed as their first language. This, however, may not always be the situation, which created an obstacle to accurate and effective communication and health education. Many migrants come from indigenous areas of Guatemala and Honduras, in addition to Mexico. While most of the Mexican migrants speak Spanish as their primary language, many Guatemalan or Honduran populations speak predominantly indigenous languages. When asked upon initial contact, however, they most always respond that they speak Spanish. In some cases, another migrant must translate the healthcare worker's Spanish for the individual. Although they do in fact speak Spanish, it is either a dialect so different from the mainstream dialect of Spanish that it is mutually unintelligible, mixed with the indigenous language in their region or possibly not a primary language at all. This increases the difficulty in stressing the importance of health, nutrition and medical check-ups in these populations. In considering the difficulties in verbal communication, there are additional complications in written forms, because most migrants are somewhat to completely illiterate in Spanish. Although written communications seem on the surface a better means for health and nutrition education, they are most ineffective in groups with such high illiteracy rates.(NCFH) Therefore, the outreach specialists in Hammonton make use of leaders in each camp, called *Promotores de salud*, or health promoters, whom are selected and invited to attend the monthly *charlas*, health chats, where they are presented nutrition or health topics in power-point format, with many pictures and explanations, and often reinforcement activities.

These migrants are treated well, personally transported to and from the meetings by the driver for the health center, asked for their input on future topics and fed good nutritious meals at each meeting. They truly enjoy participating, value having a voice in the process, and are happy to help their fellow migrant workers better understand the need for health checks and screenings. This helps to further the healthcare initiatives, since health literacy in these populations is very low in general. An effort to increase awareness, when approached in this inclusive manner as more of a horizontal approach among migrants is often more effective than the top-down approach most often employed when dealing with underserved populations.(Viswanathan)

Future consideration on how to make even further use of these health promoters should prove useful in communicating and educating the migrant communities on the importance of many issues often seen as not worthy of their time or unimportant to mention.

VII. Difference between pre/post-migration health status

Generally speaking, when migrants arrive in the U.S., they are in good health and represent a strong, healthy sample of the population from their native country. However, within the time they are in the U.S. working as migrants, their health presumably changes, resulting in their return to the country of origin as less healthy and ridden with disease, often chronic in nature. Most notably, as previously mentioned, are the high rates of diabetes and hypertension. Underlying this deterioration of health status lays several influential factors. One such factor is the status of untreated disease and illness. Since migrants are difficult to track due to their mobility, it is unknown if this representation is simply a case of healthy workers staying in service positions in the U.S. and unhealthy workers being returned home in exchange for healthy ones. Yet, even in migrants who address their initial health issues and remain in the U.S., these rates are strikingly higher than in those who never migrate out of the country of origin. In

Mexico, for example, those who remain are far healthier than those who migrate, and then return to Mexico after a temporary time spent working in the U.S.(Ullmann) Other factors may be maternal health issues, related to stress or hunger while the fetus is developing. The field of epigenetics has given rise to the idea that the fetus responds to the external environment while in utero, often changing the genetic composition in response to these factors. It is plausible that the genetic make-up of these migrants in response to an environment of high stress and hunger is altered to compensate, pre-disposing the individual to certain health disparities when a normal environment resumes. This could explain the high rates of hypertension and diabetes in these populations.(Montoya)

In one case, a twenty year old migrant, Juan, presented with extremely high blood pressure of 186/ 98, quite elevated for someone of this age. When asked if his family has a history of high blood pressure, he replied that he didn't think so. He had recently come to the U.S. as a migrant worker and was asked to stay through the winter as a contractor/ lead worker. As a lead worker, he has had the benefit of free housing over the winter months and is at the point where his travel expense has now been paid in full, affording him extra money to purchase items at the quick mart or fast foods. In most camps, there are semi-permanent resident workers who own vehicles and the workers frequently consume a high amount of high sugar and high salt foods over the winter when fresh produce is less available and female migrant workers are not readily available to prepare meals for the male workers. Since female workers are often held responsible for the cooking and cleaning duties in the camps, in addition to their field duties on the farm, a lack of their presence changes the dynamics of life in the camps during the winter months. (Bail)

In a society dominated by male workers, whose health and welfare and that of their children are held above the health and welfare of the women, the result is a general ignorance to

the fact that these women migrate with and require the same services as their male counterparts. An approach to the research on these groups, with attention to the archaeology of gender, would open up different ways of interpreting the data collected from the interactions with, perceptions of and responsiveness to healthcare workers and the initiatives currently in place in these areas. A better understanding of the history of gender throughout the time period since initial European contact with indigenous peoples would enhance and better the understanding of the current views of the women of migrant farm communities.

Throughout history, our view of gender has continually influenced the decisions of those in positions of power and authority. More recently, with the onset of the feminist movements of the last century, this view has started its evolution into a broader objectivity, one which embraces a more open discourse about the nature of gender, and ultimately allows for change. This is evident in the Women's Suffrage Movement in the U.S., which eventually culminated in the 19th amendment to the U.S. Constitution, affording women the right to vote. Such political change was only possible when the view of gender became challenged, and resulted in a change of the popular roles assigned to women during the colonial and Victorian periods in America, when due to Protestantism and strict societal views women seemingly embodied much less varied and static roles in life. It was through the questioning of women at this time that they began to inquire into why certain roles are defined as feminine or masculine and essentially how these roles are assigned in the first place. Women began to challenge these allocated responsibilities and the societal and political reasons for these gender positions.

The study of gender pertaining to migrant farm workers, their marginalization and resulting nutritional inadequacies would be very helpful in further implementation of strategies and healthcare initiatives. The existing data consists of a combination of field observations of

mobile health units, community centers and religious outreach programs based in the migrant farm community of Hammonton, NJ. It is supplemented with a compilation of relevant anthropological literature from other migrant areas in the U.S. The women in these communities are highly marginalized and often completely overlooked by traditional healthcare and community outreach projects. A more complete understanding of the gender of the Mesoamerican indigenous communities throughout the past, prior to and following European contact and the resulting mestizo communities thereafter would be very useful in further assessing the roles of both the men and women in these communities, informing the outreach community in how they might better provide services to these individuals.

VIII. Migrants vs. Immigrants

When considering the progression of migrants from a temporary status to that of a more permanent resident status, a few questions and concerns arise.

Is it possible for migrants to acculturate into American society?

What is the difference between a migrant farm worker and a successful immigrant?

While most migrants are in the U.S. as temporary workers, returning to their home country at the end of the season, many migrants do apply for permanent visas and become immigrants into the U.S. In fact, Mexico currently encompasses a higher percentage of immigrants into the U.S. than any other group. (Appendix A) In some ways, migrants are different than other immigrant groups who permanently move to this country and do not traverse across the border regularly. However, it is actually somewhat common for lead migrant workers

to achieve status as an immigrant and usually are invited to bring their family to live with them. Once in the U.S. as immigrants, their foreign born children sometimes become immigrants as well, with their U.S. born children given the option for citizenship. (NCFH) In the case of Maria, who has been in the migrant community with her husband and children for over ten years, her daughter Rosita is now eligible for a workers' identification card. She now has a son who is a U.S. born child, and desires to attend nursing school and raise her family permanently in the U.S. In this way, Maria's family has made this progression through three generations into immigration. However, she and her husband are still considered migrant workers, since they still reside on the camp, in the trailer provided to them over ten years ago when they were first invited to live on the camp as contractors. Maria is more involved in the community than some migrants, but even with her church attendance at the Spanish language service in the local Catholic church, she rarely frequents non-Hispanic businesses in the community. Her daughter Rosita, on the other hand, attended school in the local public school and speaks English very well. Her language barrier will not be as great as her parents' has been. Her access to education, healthcare and opportunity will be far greater than her parents have experienced. However, the problem remains that for migrants it is extremely difficult to rise from their current status and acculturate into society as a successful immigrant themselves. The main reason given that Maria lives in a tiny cramped four room trailer with her extended multi-generational family of six people, is that the housing cost is free. She couldn't afford to pay housing costs and still have any decent quality of life. She has little opportunity to change or advance careers at this point in her life. Unfortunately, this seems the plight of most migrants, the inability to advance or arise from their situation. (Baisden) In addition, there is the constant fear of deportation within migrant

communities, due to the history of deportation and unfair farm practices involving visas and paperwork as previously discussed. (Sontag)

IX. Problems with Existing Healthcare System

In an attempt to serve thousands of migrant workers in only a few short months, healthcare attempts often fall short of expectations. Funding for these services and programs is fairly limited and somewhat difficult to obtain. Although government funding is available to healthcare centers, the knowledge of how to apply for this funding and the willingness of the healthcare staff to perform the duties must first be present. Additionally, due to the limitations of the funding available, high quality healthcare workers are difficult to attain and retain, since the pay scale is often lower than comparable positions in mainstream healthcare. Ideas often do not formulate into a plan conducive for implementation in the clinical field, and consequently, delivery of health services to the migrant population is sometimes inadequate or inefficient. (Arcury/ Quandt) Considering that in many camps where there is a short harvest season, the population rises within a few weeks from a few dozen workers in an area to thousands of workers. In Hammonton, an average of six to ten workers live year-round in each of twenty camps, whereas during the six weeks of high blueberry season, there are over 10,000 workers in this same area. Alarmingly, the staff required to perform this duties cannot be financially supported to increase by the same rate as the workers increase. Therefore, the quality of services offered is at a much lower standard, due to available resources, than during the winter months.

X. Conclusion and Final Remarks

After researching and compiling information, and subsequently observing the migrant community of Hammonton, NJ for three months, several patterns how emerged. The

marginalization which exists in migrant communities fosters isolation, stigma, healthcare disparities and sociopolitical inequality between the migrants and the outlying community in which their communities exist. Many of the factors which influence marginalization are due to the current guestworker visa program, its limitations on migrants and allowances available to farm owners. The isolation experienced is in general a social construct based on a stereotypical biased view of migrants as illegal immigrants or on the other hand, just simply ignored by the main population. In terms of stigma, many cultural and political factors underlay the dynamics which are influential factors in determining a worker's worth both in terms of his own view, as well as how he is viewed by his migrant community and the farm owner. Many healthcare disparities arise from these factors, initially based on health literacy and experience, fed by notions of stigma and ignorance to the healthcare system, further inhibited by inadequate access to healthcare. All of this feeds back into the sociopolitical system, resulting in the healthcare disparity seen within migrant communities. For change to truly occur and persist within this system, there is a need for a multi-tiered approach to further evaluation of all of the related systems. In addition, the field research, which informed this study was limited to only a specific data set available in an off-peak time period in the winter months in a migrant setting. Further, more extensive research in this area during high season, coupled with research in other areas of the U.S. would prove useful for comparison. Migrant health is essential to the productivity and long- term relationship between the main U.S. society and our invited guest workers who provide a most valuable service to this society.

Appendix A:

The top ten countries of birth of the foreign born population in the U.S. since 1830, according to the U.S. Census, are shown below. Blank entries mean that the country did not make it into the top ten for that census, and not that there are ‘no’ data from that census. The 1830 numbers are from immigration statistics as listed in the 2004 Year Book of Immigration Statistic. The 1830 numbers list un-naturalized foreign citizens in 1830 and does not include naturalized foreign born. The 1850 census is the first census that asks for place of birth. The historical census data can be found online in the Virginia Library Geostat Center. Population numbers are in thousands.

Country/Year	1830*	1850	1880	1900	1930	1960	1970	1980	1990	2000
Austria						305	214			
Bohemia			85							
Canada	2	148	717	1,180	1,310	953	812	843	745	678
China			104							1,391
Cuba							439	608	737	952
Czechoslovakia					492					
Dominican Republic										692
El Salvador										765
France	9	54	107							

Germany	8	584	1,967	2,663	1,609	990	833	849	712	
Hungary						245				
India										2,000
Ireland	54	962	1,855	1,615	745	339				
Italy				484	1,790	1,257	1,009	832	581	
Korea								0	0	0
Mexico	11	13			641	576	760	2,199	4,298	7,841
Netherlands	1	10								
Norway		13	182	336						
Pakistan										724
Philippines								501	913	1,222
Poland					1,269	748	548	418		
Russia/Soviet Union				424	1,154	691	463	406		
Sweden			194	582	595					
Switzerland	3	13	89							
United Kingdom	27	379	918	1,168	1,403	833	686	669	640	
Vietnam									543	863
Total Foreign Born	108*	2,244	6,679	10,341	14,204	10,347	9,619	14,079	19,763	31,100
% Foreign Born	0.8%*	9.7%	13.3%	13.6%	11.6%	5.8%	4.7%	6.2%	7.9%	11.1%
Native Born	12,677	20,947	43,476	65,653	108,571	168,978	193,591	212,466	228,946	250,321
% Native Born	99.2%	90.3%	86.7%	86.4%	88.4%	94.2%	95.3%	94%	92.1%	88.9%
Total Population	12,785	23,191	50,155	75,994	122,775	179,325	203,210	226,545	248,709	281,421
	1830	1850	1880	1900	1930	1960	1970	1980	1990	2000

Persons Obtaining Legal Permanent Resident Status Fiscal Years 1820 to 2010

Year	Year	Year			
1820	8,385	1885	395,346	1950	249,187
1825	10,199	1890	455,302	1955	237,790
1830	23,322	1895	258,536	1960	265,398
1835	45,374	1900	448,572	1965	296,697
1840	84,066	1905	1,026,499	1970	373,326
1845	114,371	1910	1,041,570	1975	385,378
1850	369,980	1915	326,700	1980	524,295
1855	200,877	1920	430,001	1985	568,149

1860	153,640	1925	294,314	1990	1,535,872
1865	248,120	1930	241,700	1995	720,177
1870	387,203	1935	34,956	2000	841,002
1875	227,498	1940	70,756	2005	1,122,257
1880	457,257	1945	38,119	2010	1,042,625

Source: US Department of Homeland Security, *Persons Obtaining Legal Permanent Resident Status: Fiscal Years 1820 to 2010*

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