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Migrant farmworker women and children : reaching out to them through research, intervention, and education

Migrant Farmworker Women and Children

Reaching Out to Them Through Research, Intervention, and Education

Life for most migrant farmworkers in North Carolina means unending manual labor, relentless poverty, and alienation from mainstream society. To them, adequate health care often seems an unattainable luxury. Researchers from the UNC School of Public Health, though, are working to make health care, especially for women and children, more accessible and more effective.

Kim Larson (left), Elizabeth Watkins, and Chris Harlan discuss the migrant health project.

North Carolina's Harvesters

North Carolina is located in the East Coast migrant stream, the geographical path migrant workers follow to obtain work after leaving their homebase state, usually Florida. Due to the state's long growing season and large agricultural area, North Carolina receives more migrants than any other upstream state—anywhere from 35,000 to 60,000 farmworkers each year. Most are black American, but there are significant populations of Hispanics and Haitians, and a smaller white population. Each group has its own distinct culture.

Western North Carolina farmers rely on the migrants to pick fruit; farmers in the north central region of the state need help planting and harvesting tobacco; farmers in eastern North Carolina rely on the workers to pick vegetables. The migrants may come as early as April and stay as late as November, although most work in the state during June and July.

While living and working conditions vary from farm to farm, many migrant camps are not pleasant places. Farmers usually provide shelter, but it can range from relatively comfortable structures to converted tobacco barns. Kitchen facilities are often very basic and poorly maintained, which leads to poor nutritional habits. Water is mainly cold and not always easily accessible. Toilet facilities and sewage disposal are often rudimentary.

Migrant women, in particular, face a special set of hardships. In addition to the physically grueling work they perform outside the home, they usually shoulder the major responsibility of trying to raise children under these very harsh conditions. These tasks, combined with language barriers, a lack of knowledge about available resources, and feelings of isolation and loneliness, make obtaining adequate health care for themselves and their children very difficult.

Improving the Health of Migrant Mothers and Children

Dr. Elizabeth Watkins, acting chairman of the Department of Maternal and Child Health, and numerous colleagues have designed and implemented a long-term project aimed at improving the health of these migrant women and children. "Improvement of the health

status of migrant mothers and children will contribute to a reduction in the nation's infant mortality rate and to childhood morbidity and mortality rates in general," she explains. "Provision of comprehensive health services which intervene in the physical, nutritional, social, and emotional status of these families may promote a quality of life which encourages a child to complete his education and, so, enable him as an adult to 'settle out' of the migrant stream."

The project is the result of years of research that began with a request for help in 1983 from Connie Gates, who was then director of Tri-County Community Health Center. Tri-County is a federally funded health center in Newton Grove, North Carolina, that provides health care for migrant farmworkers in Sampson, Harnett, and Johnston counties.

Photograph by Chris Harlan

Tri-County Community Health Center in Newton Grove, North Carolina

To better serve the needs of the prenatal population, Watkins wanted to learn more about them and their pregnancy outcomes, so she launched a pilot study that same year. The study was a chart review of 171 obstetrical patients and 48 infants born to women who delivered in North Carolina in 1982 and returned to Tri-County for well-child care.

In that year, the pilot study revealed, there was a high incidence of morbidity and mortality among newborn infants, visits by patients were fewer than recommended, and there were too few staff to do adequate outreach, follow-up, and coordination with other health resources in North Carolina and Florida.

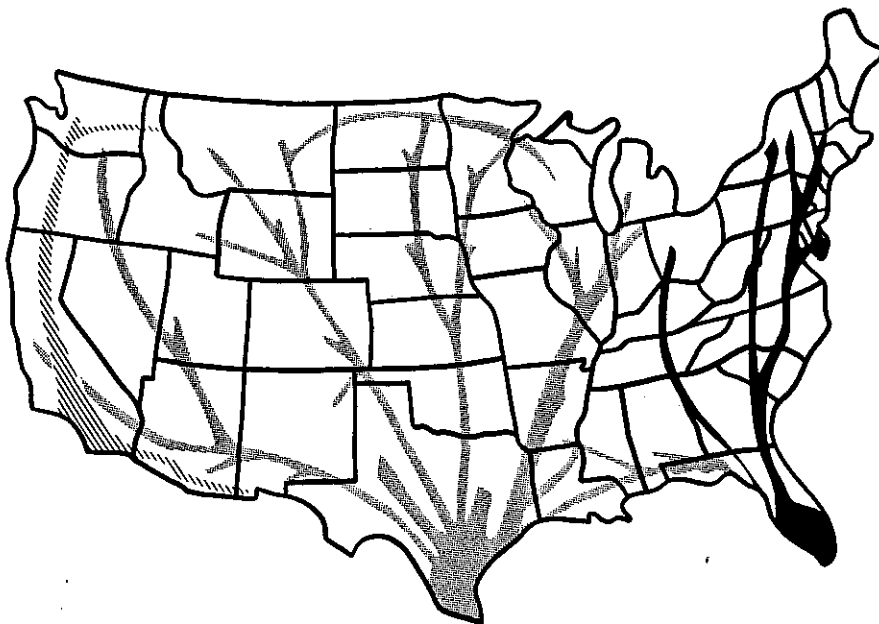
In order to improve the situation, Watkins and Gates, together with faculty from other UNC departments, designed an extensive three-year project at Tri-County that would more clearly determine the key factors associated with the migrant women's poor obstetrical and child care, alter these factors to improve care, and, ultimately, implement change in the health care delivery system serving migrant women and children. The project was funded by the U.S. Department of Health and Human Services, Bureau of Maternal and Child Health.

It was a massive undertaking. First, Watkins sought out and hired bilingual, multi-disciplinary staff. Kim Larson, project coordinator, is a public health nurse who speaks Spanish and has worked in the Peace Corps. Chris Harlan, the project's public health nurse educator, was working on the Tri-County staff when she was recruited into the project. She, too, has worked in the Peace Corps and speaks Haitian (Creole) and Spanish. Other staff included a nutritionist from the UNC School of Public Health, Suzanna Young; social workers Sue Gilbertson and Myrna Ramos-Nunez; statistical clerk Sherry Wenrich; and numerous medical and faculty consultants.

In the beginning, the project staff had to communicate with and gain the trust of the Tri-County patients—mostly Hispanics, with a smaller population of Haitians. "It's basically an international, third world phenomenon plunked right down in the middle of eastern North Carolina," Harlan says. "To me, it's the same as going to South America with the Peace Corps." Larson adds: "It was harder than the Peace Corps. I don't think any of us realized how hard it was going to be."

Another initial task was to gain the acceptance of the Tri-County staff, which usually numbers about 15 but swells to about 35 in the summer. "We all came in with master's degrees and big plans, and it caused some friction," Larson explains. Originally, it was intended that the project staff would be consultants to the clinic staff, but they found that by joining the Tri-County staff in delivery of services they were more readily accepted.

The basic design of the project was to collect baseline data, implement interventions designed to improve patient health, then remeasure the baseline variables. The project staff measured sociodemographic characteristics of both the maternity and child patients, including factors in their physical environment, health behaviors, stressors in family relationships, the family's economic situation, and



Travel patterns of migrant farmworkers. North Carolina is located in the East Coast migrant stream.

patterns of utilization of health care and social resources.

For the maternity patients, health data was collected on obstetrical history, health status during current pregnancy, and outcome of current pregnancy. The children's health data included information on their current health and nutritional status and follow-up of illnesses and hospitalization.

An important aspect of the project was to increase collaboration between state maternal and child health resources, so that migrant children can receive the same services as resident children who go to county health centers: free immunizations, referrals to child development centers, consultations with regional public health nurse consultants, and services for children with special health needs.

One of the interventions introduced through the project was an assertive education program to increase breastfeeding, launched by the project nutritionist. Through a series of multilingual group classes, 101 women learned about breastfeeding's positive nutritional aspects. The nutritionist also collected unique nutritional data that will allow her to determine the migrant mothers' and children's nutritional risk levels. "The data is a valuable contribution, a real plus," Larson says. "There's very little recent research on the nutrition of migrant workers in the eastern states."

An active social services program was another effective project intervention. The social workers interviewed families about their social situation, looking at factors such as marital stress, day care needs, substance abuse, and spouse abuse. They then provided needed services or referred the patients to outside facilities, such as mental health centers and women's shelters. They were able to help with several cases of severe wife abuse.

Photograph by Kim Larson

Black American lay health advisor with her child

"Overall, our data show improvement in health status and health behavior of the patients," Larson says. But, Watkins adds, because there are so many other variables influencing the life of migrants, it is difficult to know precisely the extent of the interventions' effectiveness. In order to complete analysis of the data, the group applied for and has received funding for an additional year.

Photograph by Tracey Maxwell

Chris Harlan (right) talks with the mother of a lay health advisor in Newton Grove. Four of the woman's six children and her husband are migrant workers.

Lay Health Advisor Program

Of all the interventions aimed at improving maternal and child health during the Tri-County project, the Lay Health Advisor Program appeared to be one of the most powerful. Among health professionals, it has also created the most interest. Consequently, the researchers have implemented a three-year demonstration project to document the effectiveness of lay health advisors.

Begun in October 1987 and scheduled to run through September 1990, the program involves educating migrant women to become health advisors to their peers. "We try to recruit women who have empathy and the ability to teach and share what they've learned," explains Harlan, who is responsible for training the advisors.

Training consists of a series of health education classes that deal with child health, women's health, nutrition, and community

resources. As the women travel within the migrant stream and talk with other women about what they have learned, they can provide a continuity of health care that individual health facilities cannot.

Because the women are members of the migrant community, they do not present barriers commonly found between medical personnel and the migrant population: different language, social class, education level, and life situation. By emphasizing a community perspective, the program also directly involves the women and their families, a relatively unique situation. "We're giving these women a chance to take control of at least a part of their lives," Harlan says.

In the words of Sharon Brown, a migrant woman who trained at Tri-County as a lay health advisor in 1986: "Being a lay health advisor means knowing about things that go on inside, around, and about you and your loved ones. It taught me things I didn't know and things I thought I knew but learned I could know more about."

The researchers hope to demonstrate that lay health advisors can help others to practice better maternal health care, improving both perinatal outcome and infant health status. To test this hypothesis experimentally, they will compare these factors at five different sites in North Carolina: two sites, Tri-County and the Nash County Health Department, will utilize lay health advisors, and three sites in Duplin and Henderson counties will not utilize lay health advisors. The estimated sample population will be 400 women, 400 newborns, and 250 infants. Larson is responsible for monitoring data collection at these five target sites.

Such a comprehensive study requires extensive organization. Twenty bilingual trainers had to be recruited from among health center staff, other health care professionals in the area, and graduate students at the UNC School of Public Health. In addition, the logistical ramifications of the program are tremendous. This year's program consists of twelve classes for three different ethnic groups. This situation necessitates recruiting and consulting with three sets of trainers, developing three sets of health education materials, procuring three sets of audio visual equipment, finding space to hold three classes simultaneously, and providing child care and transportation for the participants.

"The Lay Health Advisor Program staff has had to be very creative in developing materials for education and assessment," Watkins notes. "This is a fairly new area of research, and there hasn't been very much to draw on. Most of the data collection tools had to be specially developed."

Photograph by Chris Harlan

Haitian lay health advisor picking potatoes in the fields of Johnston County

Photograph by Chris Harlan.

Women leaving a class on infant feeding with layettes, gifts of local church women's groups. The class was held at the Tri-County Community Health Center, Newton Grove.

Although the Lay Health Advisor Program, like the three-year project that preceeded it, requires major investments of the researchers' time and energy, the staff remains highly motivated and determined. That they can see the changes they are making in some women's lives helps keep them going.

One migrant woman in the program, for example, learned how to take her child's temperature and feel the soft spot (anterior fontanelle) on the child's head to check for swelling that indicates illness. A few days later she noticed her son was running a fever and the soft spot was swollen, so she brought him to the hospital for evaluation.

The boy appeared quite ill, and the doctors, fearing meningitis, kept him for observation. Fortunately, the child did not have meningitis and under hospital care his fever subsided. This migrant mother acted quickly on the skills she had learned through the Lay Health Advisor Program—basic diagnostic techniques that will help her keep herself and her children healthier.

—Tracey J. Maxwell