Lay Health Programs in North Carolina for Migrant Women

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Ginger Bethune
Michele Collins
Naama Ende
Radha Ghosh
Laura Overkircher
Lisa Redwine

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INTRODUCTION

Description of Population

There are an estimated three million migrant farm workers and their dependents in the United States (Watkins, Larson, Harlan and Young, 1990). The exact numbers are uncertain because of the transient nature of the population, their migrations in and out of the country, the undercounting of workers who do not fit ethnic or demographic stereotypes, and the desire of many workers to avoid contact with government agencies (Rust, 1990). There are three main patterns or streams that migrant workers follow, the West Coast Stream, Mid-continent Stream and the East Coast Stream (See Appendix A). In the East Coast stream, migrant workers usually harvest fruit in the winter in Florida and work themselves up to the New England States as the growing season changes (Watkins et al., 1990). Migrant workers harvest America's crops which include tobacco, sweet potatoes, cucumbers, and fruit among other crops. Often men, women, and children work long hours in the fields. The jobs are seasonal which necessitate the workers and their families moving with the changing climate. The average annual income for a migrant family of four is $6,000 (Anonymous, 1990). These workers consist primarily of African Americans, Haitians, and those from Central and South America (Fleming & Hayak, 1984).

North Carolina has an estimated 80,000 migrant farmworkers and dependents on a seasonal basis giving the state the largest farmworker population on the East Coast and the fourth largest in the United States (Watkins et al, 1990; Fleming and Hayak, 1984). The migrants in North Carolina typically are 50-60% Black Americans, 25-30% Mexican Americans, and 15% either Haitians or white but the number of Hispanic migrant farmworkers in North Carolina have been increasing steadily since the early

80's. (See Appendix D) The large numbers of migrants in North Carolina is primarily due to the state's long growing season and its emphasis on agriculture (Fleming & Hayak, 1984).

Health Concerns

Migrant farm labor is by its nature both difficult and hazardous to one's health. The life expectancy of migrant and seasonal farmworkers is 49 years, compared to the national average of 75 years. Occupational safety and health problems include poor sanitation, overexposure to the elements, constant exposure to pesticides, and poorly designed equipment which may result in injury or death. Injury is the leading cause of morbidity and mortality among migrants. One survey reported that 44.5% of farmworker households have a disabled family member (Rust, 1990; Ciesielski, Hall and Sweeney, 1991). These working conditions are compounded by socioeconomic factors including minority status, low income, low educational status and language barriers. Housing is also an issue with families often living in substandard conditions (Jasso & Mazorra, 1984). Common medical problems seen among the migrant population include tuberculosis, parasites, venereal disease, malnutrition, alcoholism and violent injuries. The health care needs of this population present a unique challenge because of their migratory existence, low income and lack of health insurance (Fleming & Hayak, 1984).

Migrant women in particular have special health concerns due the added responsibility of child bearing and child rearing. They are often forced to raise their children in substandard surroundings and carry the full load of household chores and child rearing. The women are often segregated into certain jobs and receive lower pay than their male counterparts (Jasso & Mazorra, 1984). These circumstances impact negatively upon health and pregnancy as evidenced by an infant mortality rate among farmworkers

which is about 25% higher that the national average. Migrant women are more likely to enter prenatal care later in pregnancy, to receive fewer prenatal visits, not use family planning methods, and to have insufficient dietary intake as compared to non migrant women (Watkins, et al, 1990).

Access to Health Care

The majority of migrant workers, nationally and in North Carolina, receive their care at county health departments and federally funded migrant health clinics. However, many migrant workers are unable to access health care. It is estimated by the National Migrant Resource Program that less than a quarter of the migrant population is served by migrant health centers. The reasons for this lack of access to health care include economic , communication, and transportation barriers (National Migrant Resource Program, 1990). Few migrant workers are covered by workers' compensation or health insurance. This is primarily due to dicriminatory state policies which often do not require farm workers to be covered by workers' compensation (Demers & Rosenstock, 1991; Anonymous, 1990) Though hospitals play an important role in providing emergency treatment, inpatient care, and specialty consultation, migrants often lack access to primary and preventive care. This is evidenced in the prenatal care received by migrant women in North Carolina who average 2.8 prenatal visits per pregnancy, well below the minimum recommended 9 visits (Watkins, et al, 1990). The focus of this paper will be upon the utilization of prenatal care by migrant and Latino women within the state of North Carolina.

Review of Migrant Health Programs

In reviewing the literature, it is evident that a variety of intervention methods have been used to try to improve the health status of migrant farmworkers. Many of the programs have their foundations in health

programs designed for working with individuals in developing countries. The concept of family-carried growth records has been attempted among some migrant populations in order to overcome the problem of lack of complete medical records. These growth charts are currently used in many developing nations and provide a record of children's height and weight measurements over time (Young, Kaufman, Larson and Watkins, 1990) It seems feasible that this method could also be used with prenatal care check-ups with the woman responsible for carrying the necessary information regarding her pregnancy. Maternal care coordination which provides case management and outreach services to migrant farmworker women has also been used to increase access to prenatal care services. Positive results were reported by this program showing an increase from 35% of migrant women with first trimester entry into prenatal care in 1985 to 51% in 1989. In addition, the percentage of women receiving nine or more prenatal visits rose from 24% in 1985 to 50% in 1989 (Larson, McGuire, Watkins and Mountain, 1992). Lay health advisors are another method which has been used to improve the maternal and child health of migrant farm worker women. This type of outreach method will be discussed further in the following section.

Lay Health Advisor Programs

Lay health education is founded in the belief that communities contain individuals whom others turn to for advice and assistance. These "natural helpers" are usually long-standing members of the community who have earned the trust and respect of other community members. These lay leaders are important sources of information and support within their communities. Eng and Young describe the types of support offered by these leaders as falling into four categories: emotional, informational, instrumental, and appraisal

support. Emotional support refers to the need to be listened to and supported. Informational support includes knowledge of resources as well as practical information which community members must have in order to get their needs met. Instrumental support includes access to concrete services. Appraisal support refers to the assessment of needs of an individual based on his/her situation (Eng & Young, 1992).

Lay leaders are knowledgeable about community norms and beliefs and have an awareness of the social significance of health and disease within a community. A differention is made between disease and illness, with illness referring to the emotional, social and cultural implications of a physical disease. Only with an understanding of the community definition of an illness, can health professionals understand what measures will and will not be acceptable within a community (Holmes, Hatch and Robinson, 1992). Using community members sensitizes health providers to cultural issues which need to be taken into account in serving the community. It is also assumed that health information will be more readily accepted if it comes not from "outside" experts but instead from trusted members of the community (Salber, 1979). This would be particularly true among populations who are distrustful of the medical profession, often due to previous negative experiences (Holmes et al., 1992). It is the premise of lay health education that if these lay leaders are able to be identified and their community knowledge and position accessed, they could influence the community towards better health practices. Lay leaders could be educated as to health practices which they in turn can share with the community. In using community members, it also ensured that the knowledge will be relayed to the community in a culturally appropriate and acceptable manner.

In looking at the different types of lay health education programs, Chris Harlan of the University of North Carolina at Chapel Hill School of Public Health believes that they exist on a continuum as to level of organization. She says that lay health education programs can vary as to whether they rely on natural helpers or professional educators. Natural helpers are not paid and would not receive as extensive and professional a training as more professional educators. Provision of services can also be formal or informal. An informal arrangement would consist of a lay health educator interacting at a community level as he/she participates in everyday life, sharing information as he/she sees fit. A more formal structure could entail organized classes or groups which the educator would lead for community members. The third method for looking at lay health education programs is by whether the leaders are internal or external to the community. Internal refers to those lay persons who come from within the community while external refers to those persons who function outside of the community, for example physicians who work at a local health department (Harlan, Eng and Watkins, 1992).

Project Methodology

Our project began with a strong student interest in health issues of North Carolina's migrant workers. We met as a group and discussed migrant housing conditions, worker's compensation issues, immigration, and maternal and child health issues. The group came to a consensus on examining various models of prenatal and infant health services to migrant women. We contacted individuals at state and local agencies involved with migrant health to learn more about current concerns of this specific population. As our research efforts continued we began to concentrate on lay health programs. This type of service delivery or service enhancement

utilizes lay health workers who are often natural helpers from within the community and seems to be especially suitable to rural areas. Lay health programs work to improve the dissemination of accurate, culturally appropriate health information among the population base it serves. For the purposes of this project we will focus on lay health programs to migrant women and young children in North Carolina and compare and contrast three models of lay health activity based on a continuum framework.

Our group divided into three pairs and each pair of students selected a lay health program based on information from our previous discussions. We made site visits and conducted interviews for each of the programs. An interview guide was drafted by the group prior to the site visits to ensure that all pertinent information was obtained (See Appendix B). We were interested in the goals, services provided, and operations of the programs.

The Migrant Lay Health Advisor Program (MLHA) was the first program we examined. It is located in the Tri-County Community Health Center in Newton Grove, NC (See Appendix C for Program Locations). The program serves migrant farm workers in the surrounding areas including Latinos, Haitians, African Americans, and Whites. Madres a Madres (Mothers to Mothers) was the next program we visited. It is located in Siler City, NC and is based in a Methodist Church for Spanish-speaking people. This program serves Latino women who have settled in the area as well as the migrant population which is heavy during the growing season. Madres a Madres works in conjunction with the Chatham County Health Department to improve its health service delivery system of prenatal and postpartum care. Madres a Madres also acts to expand access to the community's health and social resources by providing transportation services, ESL classes, immigration information and health education. The final program visited

was the MOMS Program based in Hendersonville, NC which works closely with the Blue Ridge Community Health Center. This program's goal is to increase women's ability to access health and community services for themselves and their families in an effort to improve birth outcomes and parenting skills.

We realized after our site visits that the primary population served by all three programs were Latinos and decided to focus specifically on this population. Workers and their families from Central and South America make up a large proportion of migrant farm labor in North Carolina. This is a population with special issues in accessing health care. Some of the challenges for migrant workers in terms of utilizing health services include: transportation and communication problems, unfamiliarity with community resources, migratory status, lack of health insurance, and socioeconomic factors. The next three sections of our paper give detailed descriptions of the programs we examined; 1) The Migrant Lay Health Advisor Program, 2) Madres a Madres, and 3) the MOMS Program. These descriptions are followed by a comparison of the programs based on the continuums of informal to formal, natural to professional helpers, and internal to external. Specific examples are cited based on our site visits and interviews. Our paper concludes with some overall observations and suggestions regarding the efficacy of these lay health programs in North Carolina.

PART 1: MIGRANT LAY HEALTH ADVISOR PROGRAM

The most informal maternal and child health program for migrant farm workers examined was the Migrant Lay Health Advisor program at the Tri-County Community Health Center in Newton Grove, North Carolina. This program utilized the idea of the natural helper to help promote health to the migrant workers in the area. Natural helpers, or lay health advisors, are often described as: "'lay people to whom others naturally turn for advice, emotional support, and tangible aid. They provide informal, spontaneous assistance, which is so much a part of everyday life that its value is often not recognized (Watkins, 1990)." This concept is centuries old and often used in Third World countries. Two commonly known examples would be the Barefoot Doctor in China or the Village Health Workers in Mexico (Harlan, 1992)." This idea is based on the notion that in every community there are natural leaders that provide emotional support, information, and advice. These people would be the mothers, neighbors, coworkers and friends within a community. A distinctive quality of a lay health advisor is that they are internal members of the community that people turn to naturally for help, while physicians and other professionals are external, planned resources. In the migrant population, Lay Health Advisors share the same culture, language, low income status, irregular employment, inadequate housing, and overall socioeconomic status as the people who turn to them for help. Although the lay health advisor concept has been proven to be very helpful, it should be understood that they are not substitutes for physicians or a method that could be used to cut expenses. They are not extensions of the health clinic but rather a more natural source of support that exists within the cultural and social boundaries of the community.

The Lay Health Advisor (LHA) program was funded at Tri-County by a demonstration grant called "Improving the Health of Migrant Mothers and Children." This grant was awarded by the Division of Maternal and Child Health, Department of Health and Human Services to the University of North Carolina's

School of Public Health. The primary goals of this project were: 1) "to improve health status and to increase utilization of perinatal and child health services by expanding the mother's knowledge (Harlan, 1992) " and 2) "to demonstrate the effectiveness of lay health advisors in disseminating accurate, culturally appropriate health information to the migrant population and linking them with health and social services (The Maternal and Child Health Migrant Project Staff .)" Another objective was to improve continuity of care to migrants as they travel between North Carolina and Florida.

The Department of Maternal and Child Health at UNC-CH started collaborating with Tri- County, a federally funded health facility that serves North American, Hispanic, and Haitian migrant and seasonal farmworkers, in 1982 and 1983 when they conducted a study of medical records of 171 women farmworkers who had received prenatal care. The study determined that there were no regulations or protocol when dealing with pregnant women or children. They discovered that only thirty-nine percent of the patients had records on pregnancy outcomes. Also, only forty-two percent of the women received prenatal care in their first trimester and had an average of 2.7 visits during their pregnancy. 7.7% of the infants had low birthweight and only sixty percent of the mothers returned for postpartum visits. Lastly, of the forty-eight newborns who had records, fourteen had severe diarrhea and eight infants were hospitalized (The Maternal and Child Health Migrant Project Staff, 1990). Thus, the findings of the 1983 study were disturbing. This led to the project which moved into its main planning stages in 1985 when the Department of Maternal and Child Health and Tri-County started to develop a more continuous and comprehensive health care system for the migrant population (Larson, 1992).

The project was not designed to reverse problems within the clinic. The Lay Health Advisors were "identified and provided an opportunity to learn more about

the kinds of concerns they handle naturally (Harlan, 1992)." The staff used a reputation method to select the Lay Health Advisors. They considered people who were described as respected, trust worthy, interested in learning more to help their community, and had a sincere interest in helping their neighbors. Participants were usually recommended by the Tri-County staff, the project staff, and more recently by the lay advisors themselves.

The Lay Health Advisors consisted of fifty-eight percent Latina women, twenty-three percent American Blacks, twelve percent American Whites, and six percent Haitian. Forty-nine percent of the women had less than eight years of education and over seventy percent of the Latinas and Whites were married while only thirty percent of the African Americans were married (The Maternal and Child Health Migrant Project Staff). Also, the ages of the women ranged from fifteen years old to fifty-two years old and the majority of the women fell between the ages of twenty and thirty years of age. Lastly, a common characteristic for all the women was their status as migrant and seasonal farmworkers and the common plight they faced in dealing with irregular employment, low wages, language barriers, low education levels, and inadequate access to health care.

The project staff was located on a full time basis at the Migrant Health Center and worked to develop culturally appropriate strategies for delivering care to migrant women and children (Larson, 1992). The trilingual staff consisted of a Public Health nurse, a nurse Health Educator, a nutritionist, and a social worker. In addition to the permanent staff, various guest teachers and specialists were invited to lead training sessions. In the planning stages, the staff administered a pre-program survey to the Lay Health Advisors to determine the topics they were interested in studying. This led to a sense of ownership for the LHAs and the development of the topics for the twelve week training sessions which will now be discussed in this paper.

The training sessions were the highlight of the migrant Lay Health Advisor project. Located in the migrant camps or Tri-County Health Center, depending on the preferences of the participants, the training workshops were held once a week on Sunday afternoons for three or four hours. Sundays were designated as training days because it is the only day of the week that migrants do not work. Sacrificing this day of rest showed these women's dedication and commitment to improving the quality of life for their community and themselves. The provision of child care and transportation on Sundays made it possible for the women to participate in this project.

Each week a different topic was discussed in an interesting, informal, and interactive environment. The topics covered during these sessions included: child health, nutrition, women's health, and social services. Culturally appropriate materials, such as videos and poster, were utilized as well as skits and open discussions. One farmer trainee felt that everyone learned a lot during these sessions because of the supportive and social atmosphere.

After the first three years, the program was evaluated and many of the outcomes were positive. The staff first discovered that a higher proportion of the women at Tri-County initiated prenatal care in the first trimester and that a significant increase was found in a proportion of babies who had normal hematocrit or hemoglobin levels (Harlan, 1992). Also, an increase in knowledge was found in the Lay Health Advisors by a pre- and post- test. The pre-test had a score of sixty percent and the post-test had a significant increase at an overall of eighty percent (Harlan, 1990). After the Lay Health Advisors were trained, it was discovered that twenty percent more women made a post partum visit to the health clinic and that forty-six percent of the women who came to the clinic recognized a natural helper (Watkins, 1990). Furthermore, the percent of women breast feeding increased from thirty-one percent to fifty -two percent and the amount of sick visits for children

decreased from an average of 4.5 visits in 1985 to 3.1 sick visits in 1987. It was also discovered that the incidence of diarrhea decreased in the overall infant population who visited the center (Watkins 2, 1990). Lastly, the staff themselves recognized a closer working relationship with other health centers and social organizations between North Carolina and Florida (Watkins 2, p. 572). It was very difficult to actually gather data on the success of Lay Health Advisors since most of their work goes on in homes of family and friends and are thus often unobserved. However, as the data collected from Tri- County shows, there was an improvement in the overall health and behavior patterns of the children and mothers of the area.

Lay Health Advisors served as advocates for their peers and were symbols of "every mothers knowledge." The program had many positive attributes such as free refreshments and convenient times and locations. Transportation provided by a church bus or the local Head Start program would pick up the participants. Often, staff members themselves would pick up trainees as needed. The program also offered free day care for mothers who may not have been able to participate because of family needs. The staff was Trilingual so language barriers could prevent no longer open communication and participation. The program was empowering for the women. It eventually led to a grant that funded similar programs in four other sites in North Carolina. One farmworker trainee Sharon Brown stated that the best thing about the program was the social support the group provided. She felt that migrants only trust those they know. Sharon also felt that the situation led to a lot of sharing that only increased the existing bonds between the women. For this particular trainee, the program solidified her interest in the health field. Sharon is now working on her nursing degree. She also stated that the training dispelled a lot of myths simply because the Lay Health Advisors themselves intimately know the myths and beliefs that exist within their culture and community. Lastly, she felt

that the trainers were excellent and interesting and that the program was so complete that she would not change a thing.

Although there were many positive attributes of this program, one factor brought to our attention was the anthropological implications of having such an empowering program for a population of women who are usually oppressed. "Is the intent of the program to train LHAs to better wives and mothers or is the intent to help women critique the role of wife and mother in society (Harlan, p. 11) ? " Another concern, is the fact that the grant was limited in time and funds, so many of the useful services listed above are no longer available at Tri-County due to the decrease in support.

PART 2: MADRES a MADRES

Madres a Madres is a 1-year old lay health educator training program located in Siler City, NC. The mission of the program is to train Latino women in prenatal and postnatal health issues so that they can share their knowledge with other community members. The program is run by the Chatham County Health Department and was conceptualized as part of the Helping Families program which matches needy women with natural helpers. These natural helpers are similar to the ones described in the MLHA Program. Madres a Madres was started to meet the needs of an increasing Latino population in the Siler City area. In addition to training lay health educators, Madres a Madres serves the purpose of reducing the isolation of these women, allowing them time away from their children, providing socialization for the children, encouraging independent thinking, teaching the women English and increasing the participation of Latino women in Health Department services.

The funding for the program is a mix of Medicaid funds, Department of Health funds and a recently received grant from the March of Dimes. The program is currently in its second year and the first year it was run through donations of time, money and space. The March of Dimes funding has allowed the program to provide better services but the funding is only slated for one year. More permanent funding will need to be sought in order to continue as well as enhance the program. The Latino population in Siler City consists of migrant farm workers as well as factory workers who have either settled out of migrant farming or have come specifically to work in the numerous chicken processing plants in the area. The numbers of Latinos have been increasing in Siler City in the last five years and it is estimated that the Siler City primary schools are 20% Latino. Most of the Latino population

in Siler City is originally from Mexico but several other Central and South American countries are also represented. Though the majority of the Latinos are men, women and children often accompany the men. Many of the women are young and often pregnant. While most of the men are documented aliens, most of the women do not have legal rights to reside in the United States. Though many of the women work, many also stay at home to care for their children. These women are often very isolated and are not aware of the health and social services which are available to them. They often speak little to no English and have few support networks, having left their family and friends in their native countries. Housing conditions are very poor among the Latino population and there is often no heat available. Domestic violence has been identified as a significant issue in this population which is isolated from natural family support structures. Working conditions for the men are often very harsh and pay is low. The major needs which the health department has identified among this population includes the need for earlier access to prenatal care, increased opportunity for employment and education and improved housing conditions. The situations of the Latino population in Siler City point to emergent needs to which the Madres a Madres program seeks to respond.

Madres a Madres is a lay training program formed in response to the needs of the pregnant and parenting Latino women within the Siler City community. Women are chosen for the program who are Latino and are either pregnant or parenting. Most are identified while they are pregnant. Women are invited to participate in the program primarily by health department staff. Other referrals to Madres a Madres come from churches, community organizations and word of mouth from participants. Participation seems to be according to self-selection in that many women are

invited but those who follow through are those who want to participate, get the approval of their husbands, and are able to arrange work and child care schedules.

The training program lasts one year and meets every Friday at a local Latino church which donates the space for the groups. The group provides training in prenatal care, nutrition, postnatal care, family planning, etc. The group is currently composed of 10-12 women who range in age from 20 to 28. Most of the women are undocumented and are recent immigrants to the area. They speak little English and are often isolated from each other as well as from accessing health services. Their husbands or partners are primarily employed in tobacco fields or processing plants. Program expectations for these women are that they attend training sessions and then share the information that they receive with other women.

The Madres a Madres group is led by two Latino women, one of whom is a psychologist originally from Argentina, the other of whom is a health educator originally from El Salvador. They are both fluent in Spanish which is necessary as most of the women speak little to no English. The fact that these two women are originally from South and Central America enables them to make the program culturally sensitive and appropriate. These two women volunteered for the first year of the project but were recently able to obtain minimal funding for their services through a March of Dimes grant . Their role is primarily as educators, but they also act as models and encourages. They are extremely concerned with positively reinforcing the women being trained. One way in which the women are encouraged is by presenting them with certificates of recognition for their participation which they are able to take home and display in their homes. Home visits are occasionally made by the group leaders and other members of the health

department in order to encourage attendance. The group environment is warm and encouraging, and it is evident that this environment is extremely nurturing for group members. Melita, the health educator, says that the women usually know the necessary information to care for themselves and their children but they need the support and encouragement to trust in their knowledge. She also says that it is important to remember that these people who leave their homeland to find a better life are the cream of the crop: hardworking, high achievers and willing to learn.

A unique aspect of Madres a Madres is that the leaders believe that prenatal and postnatal health can not be extricated from the environmental issues present in the lives of these women. They believe that in order to empower these women to take control of their reproductive health, they must also arm these women with the necessary tools to gain control over other areas of their lives. Thus, the group has invited representatives from immigration to discuss issues of residency status with the Madres a Madres group members. ESL (English as a Second Language) classes are also provided weekly at Madres a Madres by Central Carolina Community College in Chatham County. This helps the women with their English fluency in order to increase their ability to navigate life in an English-speaking environment.

Transportation to and from the group is provided by the health department and child care services are provided by volunteers from the community and by student volunteers in a child care curriculum at a local college. Child activities are often the only socialization which these children get outside of their immediate families. When children first join the group they have often never been away from their mothers and are extremely fearful. As the children adapt they are eager to play with educational toys to which they often do not have access at home and to play with other children

their age. Lunch is provided for mothers and children after the morning training session and ESL (English as a Second Language) classes are taught for the women after lunch. Though it is a long day for the women, for some of them it is their only day out of the house, away from their children and their only chance to socialize with peers.

Though no formal assessment of the program has been completed, Bill Leil of the Chatham County Health Department has seen lay education take place. Last year about 20 women were trained and about 8 of them are currently natural helpers, having been matched with individual women identified at the Health Department as in need of an advocate. The current group of women recently presented a session to congregation members after a Catholic church service and intend to present a session to another church in the near future. One of the group members has been active in both recruiting new group members as well as ensuring that her pregnant friends access to Department of Health services. Mr. Leil of the Chatham County Department of Health says that a difficulty with measuring the program's effect on birth outcomes lies in the fact that Latinos have only recently been broken down within the Chatham County birth statistics.

What Madres a Madres has demonstrated is the power of community support which has enabled the program to exist through the provision of space, volunteers, child care help, etc. Mr. Leil sees the needs of the Latino population as growing and changing. Currently, most of the immigrants are young and have young children but the children will soon be going to school and women will be looking for work within the next few years. Mr. Leil conceptualizes a Hispanic Resource Center as a possible response to these evolving needs. One outgrowth of the group has been the establishment of a Head Start program primarily for Latino children which will begin next year

at the same church which houses Madres a Madres. Currently, many of the Latino children enter the local school system speaking no English and lacking many school readiness skills that other children possess. The Head Start program will address some of these concerns.

The Madres a Madres program is certainly an impressive locally developed response to the needs of pregnant and parenting women in the Siler City Latino community. They seem to have made it culturally appropriate and an important source of support for the women. The fact that a Head Start program will be an outgrowth of their activities is commendable. Some recommendations for the program would include performing an assessment in order to document the effects of the program. This is important in order to get future funding but also in being a model for other communities with similar needs. It might also be advantageous to conduct outreach in the Latino community in order to identify "natural leaders" who may already have an influential role in the community. Most of the women trained are young and new to the community. Though it is important that they are able to participate in Madres a Madres, it may also be helpful to get other more well-established community members to participate. Obtaining permanent funding sources is also imperative in order to assure that the program can continue and develop further. The idea of a Hispanic Resource Center may also be an object for future development in order to meet the changing needs of the Latino community in Siler City.

PART 3: MOMS

MOMS, a program started in 1991 as a response to high infant mortality rates among migrants in North Carolina, addresses substance abuse as a risk behavior. The overall goal of MOMS is to increase women's ability to access and use services available in the community, for themselves and their children, and to improve parenting skills and birth outcomes. The program is strictly targeted for pregnant women and women with children under five years, but great effort is made to refer other women to appropriate resources. The services provided to women are not limited to merely reproductive health, but the MOMS program also takes a holistic approach in that whatever needs are perceived as important to the woman are addressed such as housing or employment problems. This is significant because MOMS recognizes that stress can be detrimental to pregnancies.

The MOMS program serves Rutherford, Henderson, McDowell and Polk Counties of North Carolina, with a main office in Hendersonville, and two satellite offices in Rutherford and McDowell Counties. Polk County is served by referrals made through the local health department. The program targets at risk women in the community who are pregnant or who children age five or younger. The program works with white, African-American, and Latino women in the four Counties mentioned. The Main office of the MOMS program, located in Hendersonville, works closely with the Reynolds Women's Center at the Blue Ridge Community Health Center (BRCHC), also in Hendersonville. Women receive medical care at the BRCHC clinic and the two satellite clinics of Valley, in Rutherford County, and North Druid Hills, in McDowell County.

The MOMS program is staffed with a Maternal Care Coordinator (MCC), five Mother's Advocates (MA) and a Wellness Coordinator. In following the focus of our topic, we primarily looked at the role of the MAs in the MOMS program. It is important to see how the different team members interact to provide services to the

women in the MOMS. The MCC screens clients for substance abuse risk factors, refers clients to the MOMS program, and follows clients who refuse MOMS services. The Wellness Coordinator provides assessment of cases, case management, and follow-up care for pregnant and postpartum clients identified as at-risk for substance abuse. She also provides individual counseling, facilitation of group counseling sessions, and referrals to appropriate services, besides MOMS. The grant provides for a MSW on a contract basis in Henderson County as needed. MCC, MAs, and the Wellness Coordinator work together as a team to provide comprehensive health services with a goal of reducing the risk for substance abuse in pregnant women and women with children five years and younger. All members of the team discuss client's needs to more effectively deliver services. Confidentiality is a very important aspect of care and is strictly maintained by providers at all levels.

The Mother's Advocates provide transportation, assist clients in meeting basic needs such as employment opportunities, and provide support and encouragement during and after pregnancy. Two of these women also function as Doulas (professional birth assistants). The MA's qualifications are that they must be a resident of the target community, be an able listener, exhibit a concern for community issues, be willing to participate in training, and work well in a team environment. Candidates for the MA positions who meet this criteria receive training in such areas as prenatal issues and substance abuse risks. MA's use the Health Center vans to transport clients to and from appointments. There is a Medicaid office and WIC counselors in the BRCHC clinic. Social services can be obtained in one location which makes it easier for families. Child care is also provided for these women during their appointments. There are two playgrounds, and an effort is made to feed the children and mothers at the appropriate times of the day.

MOMS is financed by a grant from the Center for Substance Abuse Prevention(CSAP) for a five year period, to be renewed annually. They are almost finished with their second year.

MA's tend to develop a close relationship with clients because of time spent during transportation to services. Drives can be as much as forty five minutes one way. During this time MA's have the opportunity to informally counsel women on topics like family planning and breast feeding and answer questions the women may have about child care and related issues. The advantages to the MOMS program is that the team approach provides consistent care for the women in this rural area. This approach also helps the health care providers to identify and address other environmental stresses in the woman's life that may be contributing to substance abuse or an unhealthy pregnancy. MOMS helps to make health care assessable to the different cultures of this rural community by attempting to bridge the gap between clients and health professionals.

Trust is an important component of relationships between MA's and clients because this facilitates informal counseling and allows MA's to provide emotional support to clients. This emotional support can lead to the client depending on the MA too much. This close relationship also provides MA's the opportunity to address information to which formal providers of care may not be privy. The program is well known and appreciated by women including migrant women in the community.

A weakness is that clients may become too dependent on MA's for transportation and translation which may inhibit the women from finding permanent solutions to these barriers. Also when migrant farmworkers come to this area to work during harvest season the staff is overloaded with additional clients. There is a lack of Spanish material and staff to address the needs of the

Latina women. There is limited funding to hire new staff, and new solutions are needed to carry on the program when the current five year grant ends.

COMPARING AND CONTRASTING 3 MIGRANT PROGRAMS

Migrant Lay Health Advisor Program

Location: Started in 1985 at Tri County Community Health Center, Newton Grove, NC

Funding: Grant from the Department of Health and Human Services for the improvement of the health of migrant mothers and children

Goals: (1) To improve health status of migrant mothers and children (2) To increase the utilization of health care services in this population (3) To demonstrate the effectiveness of Lay Health Advisors(LHA) (4) To improve the continuity of care to migrants in the stream

Services: (1) Train community leaders to be LHAs in 12 weekly sessions 3-4 hours each (2) Provide day care, transportation, and refreshments to trainees (3) Maintain full time, trilingual staff consisting of a Public Health Nurse, a Health Educator, a Nutritionist, and a Social Worker (4) Provide culturally appropriate, client oriented strategies of health care delivery

Results: As of 1988 (1) Higher percentage of first trimester, client initiated prenatal care (2) Increase in proportion of babies with normal hematocrit levels (3) Twenty percent more women attended a post partum visit (4) Breast feeding rose from 31 to 52 % (5) The number of sick visits for children decreased from an average 4.5 in 1985 to 3.1 in 1987 (6) Incidents of diarrhea decreased in overall infant population who visited the health center

Conclusion: An overall increase in health and behavior patterns of mother and children in the Tri County area

Advantages: (1) Population is more accepting of locals rather than outsiders (2) Local leaders know specific problems, myths, and barriers (3) Cost effective

Problems: (1) Anthropological implications of empowering women in a population where women are generally oppressed and dominated (2) Limited funding

Madres a Madres

Location: Started in 1992 by the Chatham County Health Department

Funding: Medicaid reimbursement funds from the Department of Health and a grant from the March of Dimes Foundation

Goals: (1) To train Latino women in prenatal and postnatal health issues so they can share this information with other community members

Services: (1) Train 10 to 12 Lay Health Educators with 1 weekly session for 1 year and certify the participants completion of the training (2) Offer English as a Second Language classes to women (3) Provide transportation, day care, and lunch to trainees (4)Provide bilingual training staff to educate, support, and encourage Lay Health Educators (5) Provide activities for children that re socially and educationally oriented (6) See health issues as a part of environmental issues in order to empower women to gain control over other areas of their lives (7) Match at risk Latino women with a Lay Health Educator

Results: No formal assessment has been completed, however, the program is well supported and appreciated by the community. A Head Start program has been established for Latino children to begin in 1994.

Conclusion: It is too soon to say.

Advantages: (1) Reduces isolation of women (2) Provides support for women (3) Provides socialization for children (3) Meets needs of children (4) Provides culturally appropriate information and training to members from the Latino community (5) Identifies needs of the community such as the Head Start program

Problems: (1) Limited funding (2) No formal method of assessment and evaluation (3) Need for better methods of identifying natural leaders in the community because current trainees are young and new to the community

MOMS

Location: Started in 1991 in Hendersonville, NC to serve Henderson, Rutherford, Polk, and McDowell Counties.

Funding: A 5 year grant (to be renewed annually) from the Center for Substance Abuse Prevention (CSAP)

Goals: (1) To lower infant mortality rates and improve birth outcomes among women (2) Provide counseling and support to women who are either substance abusers or at risk for substance abuse (3) To increase access to health care and community services for women and children (4) to improve parenting skills

Services: (1) Provide case management to pregnant women or women with children 5 years and younger (2) Provide risk screening, counseling, and support for those women who are at risk for substance abuse (3) Provide transportation to doctor's appointments for women and children (4) Provide meal and snacks at appropriate times (5) Maintain clothes closet with free clothes and other items to those women and children in need (6) Provide information for accessing community services (7) Provide informal and formal education for women in basic health areas (8) Provide Doulas to provide support, encouragement (and translation for Hispanic women) during labor and delivery

Results: No formal assessment has been completed, however, the methods and criteria for evaluation are currently being developed. The program is well known , used and appreciated by migrant women in the area.

Conclusion: It is too soon to say.

Advantages: (1) Team approach provides consistent care for migrant women (2) Team also attempts to identify and address any environmental stress important to migrant women (if this is possible) (3) MAs help migrant women negotiate in unfamiliar cultural settings (4) MAs are privy to health information about migrant women that physicians may not know

Problems: (1) Clients can become dependent on MAs (2) MOMS has a legal liability for the MAs (3) Limited funding (4) Staff has heavy client load during peak harvest season (5) Lack of Spanish speaking staff and materials

CONCLUSION

All of the programs we examined use the community members to address the maternal/child problems within. This informal culturally appropriate method not only provides important education to these women, but also much needed emotional support. Great effort is made in all these programs to encourage migrant women to be comfortable in these casual learning environments. Indeed a strength in all the programs is the strong rapport established between workers and clients. The workers, whether paid or volunteers, enjoy their status in the community and are motivated to help their neighbors. This is a cost effective, client friendly approach.

Two of the most basic barriers to assessing health care in the migrant community are easily solved by these programs. Transportation and language barriers become teaching situations as Spanish speakers take these women to their appointments. All three of the programs address similar problems in unique ways. They all have strengths and areas for improvement.

Strengths and Suggestions

The MLHA program discussed in Part I, is the only program of the three to have a complete and thorough assessment, and their program is being duplicated in four nearby communities. This replication of the program attests to the success of the program as well as the sound organization and set up. This is key for continued success and also for attraction of future funding.

The Madres a Madres Program has extensive training for their lay health educators, but needs a better method of reaching the natural leaders of the community. Training young women who are new to the community may limit the program's effectiveness. One of the most impressive aspects of the Madres a Madres program is its utilization and dependence upon volunteers. This not only

encourages a sense of community ownership, but also limits the dependence on outside funding. This program initially only paid two founders which organized volunteers to do outreach, transportation, and even teaching English as a Second Language. Madres a Madres has been very successful in mobilizing volunteers. Also of concern for the Madres a Madres Programs is the lack of clearly defined protocols and assessment methods which could inhibit the future replication and funding of this program.

The MOMS Program has clear goals and is flexible in trying to meet them. The MA's are well trained and are kept very busy. The MOMS program, however, is liable for the MAs and the information they give clients. Thus, there is a need for the outlining of protocol on these issues that lay health volunteers do not need because their dissemination of information is not subject to the same standard of legality. The program is also in need of more bilingual staff, however, they realize this need and are currently attempting to address this issue.

In evaluating these programs we came to several conclusions. First, lay health programs are effective in the migrant community. The use of culturally appropriate information and training addresses the diverse ethnic backgrounds found in the East Coast Stream. Also, we discovered that migrants more readily accept and trust those from their own background. Second, we saw the benefits of having an established protocol and thorough assessment so that the program could be replicated in another site. Third, we noted that networking between the various programs could benefit everyone through the exchange of ideas and resources. Last, the stark necessity for increased funding of preventive health interventions for the migrant farmworker population are desperately needed.

Successful and innovative solutions such as the lay health advisor programs we visited could and should be applied to other migrant communities around the state. The funding for programs that illustrated a significant impact on the target

population such as the MLHA Program often end when real results are beginning to be seen. Programs are then forced to struggle to find ways to keep the program functioning on limited funding. This severely inhibits and delays hard won progress these programs achieve.

As one can see, the continuum of maternal and child health care for migrant women passes from natural support, informal help, and professional resource assistance. Each level on the continuum addresses different needs of migrant women and their children. In the Migrant Lay Health Advisor Program natural, informal support is addressed by improving the natural helping abilities of a specific group of women in the migrant community through "every mother's knowledge" training. Not only do the lay health advisors gain support and knowledge, but more importantly, as members and natural leaders in the community, these women are able to fulfill the social, mental, and spiritual health needs of their migrant female friends and relatives who naturally ask for help with everyday questions or social support.

In the Madres a Madres Program informal support and increased knowledge of mother's issues are addressed. By matching the at risk Latina women with other Latina women who have been trained as Lay Health Educators, this helps meet the emotional and social health needs of those women who are at risk. The MOMS Program provides a bit more structured assistance for migrant women by lending pregnant and postpartum women a helping hand through organized appointments. The trained Mother's Advocates are actually paid to provide services such as transportation and arranging physician appointments for their cultural counterparts. In this way migrant women's needs are met by reducing the barriers to seeking care as well as through the more formal, organized social support of education and counseling. Following the continuum of maternal and child health care options for migrant farmworker women to its last and most formal method of

delivery one arrives at the role of the nurses and physicians. The function of physicians and nurses for migrant women and their babies during pregnancy and infancy is clearly an important one. The physician also addresses the needs of migrant women but is a more planned, direct service than a lay health person. Needs such as physical examinations and delivering the baby cannot be met by lay health advisors. These needs must be administered to by physicians and nurses so that migrant women can receive this necessary medical attention to maintain their physical health. Through scientific and organized procedures, doctors and nurses provide the most objective health care to migrant women, thus the most formal. Although an assessment and analysis of physician services for migrant women is not a part of this project it is none-the-less a crucial aspect of maternal and child health care.

The most important aspect of the continuum of maternal and child health care for migrant women is that it is a collective approach to health care. All parts are equally important and any program or intervention can address many different parts of the continuum at one time. But in order to achieve holistic health a woman ideally should receive all levels of care ranging from natural help, informal help, planned companionship, and professional resource assistance.

APPENDICES

Appendix B: Outline of Interview Questions

1. What is the mission/goal of your program?

2. What services do you offer?

Medical?	Transportation?
Counseling?	Case-management?
Advocacy?	Educational?
Training?	Outreach?

3. How are these services offered? How does the program work?

4. Who provides the services? How may people? What is their educational level? How are they trained? What are their roles?

5. Are these services offered seasonally or all year round?

6. Are the services used more often at certain times of the year? When? Why?

7. Where are the services offered? One site or at several sites? Satellite locations?

8. Who does it serve? Only migrant workers? Latinos? Blacks? Men? Women? Children?

9. How many people are served annually/monthly? Do you want to increase these rates?

10. How do people find out about your program? Are people referred to your program?

11. Do you conduct outreach? How do you outreach to people? Which group is the most difficult to outreach to?

12. Who funds the program? Is it a permanent program or will you need to get other funding?

13. Do you work in conjunction with any other programs? How does this cooperation work?

14. What efforts are made to make the program culturally appropriate for different populations? language? method of providing services? location of services?

15. When and why was the program started? Has it altered its mission since its inception?

16. Has there ever been any opposition to the program? If so, from whom?

17. Do you feel the program is effective? Why or why not?

18. Has the program been evaluated? What were the results of the evaluation?

19. If you could improve the program in any way, what would you add or subtract?

20. Are there any articles, books or materials that you would recommend to us?

21. Can we contact you if we have any additional questions?

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Interviews

Sharon Brown (Personal Communication, November 8, 1993)

Melita Colindres (Personal Communication, November 12 and 19, 1993)

Chris Harlan (Personal Communication, October 11, 1993)

Laura Hodgeson (Personal Communication, October, 26 1993)

Bess Kennedy (Personal Communication, November 10, 1993)

Maria Lapetino (Personal Communication, November 12 and 19, 1993)

Bill Leil (Personal Communication, November 12 and 19, 1993)

Patricia (Personal Communication, November 10, 1993)

Kelly Spangler (Personal Communication, November 10, 1993)