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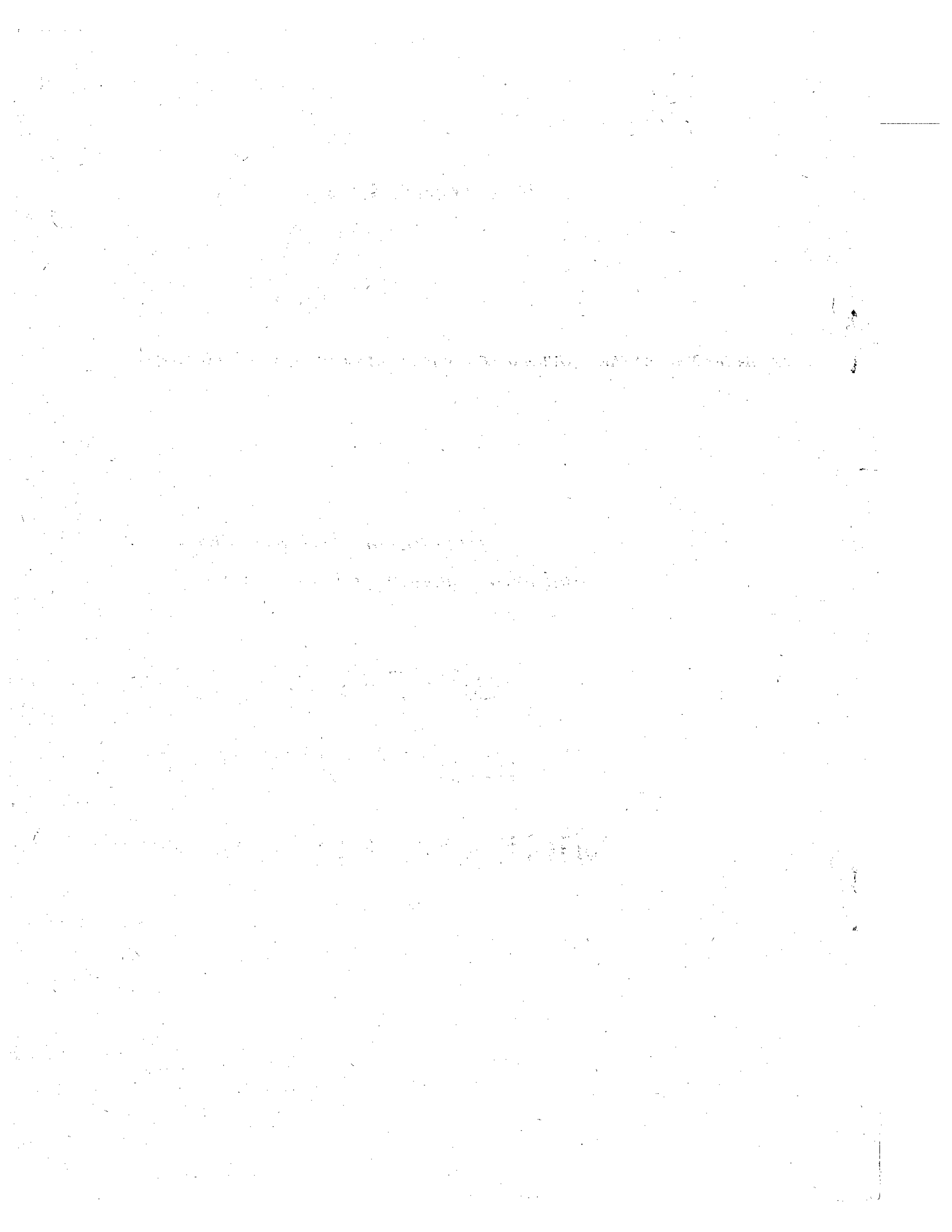

How teamwork between the State and local communities is striving for . . .

BETTER HEALTH FOR COLORADO'S MIGRANT CHILDREN

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IN THE SPRING OF 1955, a truck carrying 52 people overturned on a highway in eastern Colorado. One infant was killed and several passengers were injured. The passengers who were not hospitalized pressed on to Wyoming to the work in the beet fields for which they had been recruited in Texas. Since to these agricultural workers the loss of a few days' work at the height of the season might make the difference between one or more meals a day the next winter. For those who could not go on, the sugar company provided medical care and housing, clothing, and a funeral for the dead infant. Nevertheless, some long drawn out problems remained for three families who, when hospitalization was no longer required, were lodged at the labor camp in Fort Lupton, Colo.

One man who had suffered a head and nerve injury in the accident came to the camp clinic because of headaches, and because he could not use his right hand well. He was unable to work, and while the sugar company furnished groceries, the family's only money came from what one child could earn picking beans. Yet, although this man was obviously worried about his injury and willing to cooperate in what he understood, he failed to return as recommended to the hospital 25 miles away for checkup and treatment to prevent a permanent handicap.

At this point the clinic called in a medical social worker. She found that nobody in the family spoke English and that the father did not know how to get to the hospital and had no means of transportation. The trucker who had persuaded him to come north to work for the first time, and on whom he depended for most arrangements with the Anglo world, had gone off to another State.

The medical social worker secured appointments at the hospital for the injured man and arranged for the hospital social worker to guide him. He was accompanied to the hospital for his first visit, shown how to use public transportation to return for his treatment, and given lodging near the hospital when he needed it. Interpreting the personal and medical needs of this man and his family to the sugar company and interested agencies, the medical social worker also helped work out a plan for their rehabilitation.

The Health Program

Helping this family to become self-sufficient again was a small but definite triumph, made possible because of a health program for agricultural migrant workers which had just got underway in two counties in Colorado. In July 1954 a project was agreed upon between the Children's Bureau, Department of Health, Education, and Welfare, and the Colorado State Department of Public Health for improving the quality and availability of health services to mothers and children of migrant agricultural workers who come into Colorado. This involved setting up a minimal State structure for coordinating various local plans and then proceeding community by community to organize plans which would fit the needs and facilities of individual localities. At every step consideration was given to improvement

of communications: between the migrant workers and local residents; the agencies and the individuals concerned; the local communities within the State; and the States through which these migrants traveled.

The two largest camps in Colorado were originally built by the Federal Government under its wartime farm labor program and provided with clinical facilities. When the camps were later taken over by the local growers, the clinical facilities were no longer staffed except during the summer of 1949 in Fort Lupton.

In the spring of 1954 the Federal Public Health Service and the State and local health departments cooperated in a program of screening migrant families passing through Fort Lupton on their way to other areas to work. Emphasis was particularly placed on tuberculosis and venereal disease. The program was extended through the growing season to long-term residents of the camp. However, they were confused by its limitations when they had health problems other than those looked for in the screening service.

Preparation

The new project got underway during the winter of 1954–55 under the direction of the chief of the maternal and child health and crippled children section of the Colorado State Department of Public Health. In addition to a special grant for its support, the Children's Bureau furnished consultation and assistance with interstate referrals through the Bureau's regional staff. An experienced medical social worker, who was thoroughly familiar with the resources of the State, was assigned by the State health department to work full time with the project. She assisted in community organization and project planning, serving as a liaison with other State and Federal agencies, as well as with those on the local scene—promoting interagency cooperation by keeping them better informed.

Both MCH director and medical social worker made exploratory visits to a number of Colorado communities to gather information about health and welfare resources already available, housing facilities, methods of labor recruitment, numbers of workers and families concerned in specific areas, and dates of peak activities. They contacted a wide variety of persons since reports of community attitudes varied considerably with the personal feelings of the individual, as well as with the philosophy of the community regarding health services and migrant laborers in general. This meant proceeding slowly, but proved to be time well spent since it helped the local people to understand that the Department was interested in planning with them and not in trying to impose a program upon them and that each feature of any program set up in the community would be mutually agreed upon by the State and the locality.

Migrants and Communities

Migrants represent diverse population groups. Some of those who come to western Colorado for the peach-picking season are relatively well adjusted socially and economically, and are able to make their own arrangements about medical and health matters if local conditions are not too bad. Others spring from a poor social and economic background within the Anglo culture and include many unstable marginal workers. In Colorado the majority of agricultural migrants have a Spanish-speaking or American Indian cultural background. The Spanish-speaking groups are by no means homogeneous, as they include descendants of early Colonial Spanish, first- or second-generation "Texas Mexicans," and some Mexicans who are not yet naturalized as citizens. The Indians come from the northern plains tribes and from the arid Navaho reservations of the Southwest.

Migrant labor is an essential factor in the growing and processing of various fruit and vegetable crops, on which the economy of some important rural areas is based. Resident labor would be used entirely if enough were available at the short peak seasons of need, for though the migrants are an asset at the times when work is plentiful, they may become dependent on the community in slack seasons. This colors the attitude of the community toward them, creating a tendency to regard them as aliens.

Local communities and groups within communities differ widely in their interest in improving the health of migrants. Some offer far better health facilities than others, but generally there has been no consistent attempt to help these people utilize available facilities to full advantage nor to teach them health principles on which to plan and conduct their lives. Acute medical problems are cared for, particularly those of an emergency nature and those which interfere directly with work potential, but many chronic problems go untended and living conditions are far poorer and less hygienic than they should be.

Growers and processors often assume some responsibility where doing so directly affects the migrants'

work potential or future recruiting. Welfare agencies often spend considerable energy in sending dependent people back to their place of residence, if that can be determined. Individuals and local groups give some direct assistance. But the majority of the families, who when working could pay something toward their medical care and who need to be guided in what is important for their health, find little of the type of assistance they need.

Two Projects

As a start in improving this situation, two local projects were set up for the 1955 growing season, based in the largest labor camps in the State. The Fort Lupton camp, in Weld County, houses a maximum of about 2,000 workers and their families, all Spanish-speaking persons from Texas and New Mexico, except for a few Indians. They come to do stoop labor in the sugar-beet fields, in small vegetables for the canneries, and in the potato harvest. The work is spread over about 4 months, although there is much seasonal variation.

The camp at Palisade, in Mesa County, can house about 1,000 persons. While the peak season lasts only about 2 weeks during the peach harvest, the camp is used from early summer for those who come to work on other fruit and small vegetables for the canneries. Many are residents of Colorado, especially the 20 percent who speak Spanish. The remainder, who drift in from almost any State in the Union, is predominantly of Anglo background, and ranges from teachers and students on vacation to unstable wanderers. There are a few Negroes.

Two extra nurses were added to each of the two local health units to work in the camps. In Fort Lupton a secretary was also supplied and local physicians served in rotation in the clinic. Provision was made for travel, supplies, maintenance of clinic facilities, and payment of fees to physicians serving in the clinics at Fort Lupton. After discussion with the local professional groups, it was decided not to make provision for dental services, for hospital services, nor for fees for service in physicians' offices. The question of payment for diagnostic laboratory services and X-ray services was left open. Hospitalization, private medical fees, and essential transportation of patients were arranged for by the community when the migrants could not provide their own.

In the Fort Lupton camp, the clinic staff consisted of a public-health nurse, a Spanish-speaking graduate clinic nurse, and a Spanish-speaking secretary. Medical clinics were held six nights a week. Some medications were supplied directly, some on prescription. A mobile X-ray unit was installed and chest plates were taken of all who could be interested in having them, although there was no attempt at mass screening. Patients were asked to pay whatever they could, up to $2, for a call at the medical clinic, but no one unable to pay was refused.

In Mesa County, a registered nurse assigned to the camp and a public-health nurse working in the camp and in the surrounding area offered first-aid and nursing service and assisted patients in securing medical care through referral to local physicians. They also provided health supervision for the day-care center set up by the workers of the National Council of Churches. A physician from the town of Palisade was on call for advice.

It was the responsibility of the nurses in both camps to induce as many of the migrants as possible to seek preventive health services such as immunizations, chest X-rays, and laboratory tests, whether in the camp clinic or in a physician's office, and to steer the children and expectant mothers into well-child conferences and prenatal services.

Use of Services

Clinic services were used at some time by 22 percent of the migrants at Fort Lupton, and 17 percent of those at Palisade. In both camps the medical conditions most frequently seen were diarrhea and upper respiratory infections.

There were 35 known pregnancies in Fort Lupton, 23 in Palisade. All who delivered during their stay in the area did so in hospitals, except one woman who was delivered in the Fort Lupton camp by a midwife because of lack of transportation. One infant died of bronchopneumonia in Fort Lupton camp. This child when seen the night before in clinic had had very slight symptoms of illness.

In Mesa County the welfare department assigned responsibility for work in the camp to one worker, who was freely available for consultation at all times with the nurses. Often they could make plans together for solving the family's immediate problems without recourse to public assistance. As a result only eight cases were referred to the welfare department for assistance during the summer, a considerable drop from the record of previous years. The medical social consultant for the statewide project gave technical consultation to the staff of both camps and some direct service to patients referred with chronic illness or with other problems.

Migrant mothers and children on their way to the camp clinic. Mothers who have received medical attention for a sick child or first aid from the camp nurse are the most apt to take advantage of the preventive services of the clinic.

During a preseason orientation period a social anthropologist instructed the camp nurses in the social and cultural aspects of the migrants' health problems. At this time the nurses were also informed that being a part of available clinical and nursing services was only a beginning of their responsibility. They were to follow up contacts and to seize every opportunity for giving a little advice or guidance or for attracting groups for informal health education. When care or advice was rejected they were to try to discover the reasons, and to keep a careful record of their experiences.

During this period the health educator of the Colorado State Department of Public Health helped the nurses prepare materials for health teaching among the migrants. In actual practice camp residents come in from work late and go to bed early. Thus, while in both camps the nurses subsequently gave talks and showed films to recreation and study groups assembled by the workers of the National Council of Churches, these were only moderately successful. The most effective teaching was done through their individual contacts in which they gave considerable instruction to mothers on infant and child care.

Our experience indicates that migrant workers will often accept health services when these are offered in terms they can understand, and that in general their medical problems are like those anticipated in the resident population but aggravated by the precarious circumstances of their lives.

The migrants' pattern of living discourages planning for the future and thus probably contributes to their failure generally to show interest in preventive health services in any degree comparable to their interest in medical care. They are not indifferent to the welfare of their children, but taking an apparently well child to a clinic gives way in order of importance to other concerns, such as making enough money for next winter's food. However, many can be led to make better use of available health facilities through contact with someone they trust who has sympathetic understanding of their problems and is able to help them plan a reasonable solution that they can carry out.

Some Case Stories

In this past summer's experience the nurses' efforts to lead the camp residents toward good use of medical and health resources ran the gamut from success to failure.

One couple in their teens came to the clinic for prenatal advice because a woman they had become acquainted with in the camp was attending the maternity clinic. The nurse helped them make plans for a hospital delivery, and persuaded the girl to nurse her baby if she could, which she had not intended to do. This proved fortunate, for the baby was born prematurely. On a home visit immediately after the mother's return from hospital, the nurse found the baby and a large doll, each wrapped in a blanket, lying side by side on the bed. She showed the young mother in this and subsequent visits how to keep the baby screened from flies and away from close contacts and explained the importance of her own diet to the baby's health. Though this was the season of diarrhea, the baby remained well and gained. The grateful young parents proudly brought their child regularly to the clinic for check-ups.

In another family the 9-month-old twins had three bouts of severe diarrhea, necessitating two periods of hospitalization. They were very sick children. Their mother was clean, conscientious, and much

interested in her children's welfare, but she was living in a shack on a farm outside the camp and no home nursing visits were made to her. This indicates a flaw in the services, for she might have been taught, by demonstration in her own home, how to protect her babies better, and particularly how to feed them. Presumably she learned in the clinic, however, for at the end of the summer the children were doing better; by then she had improved their diet and modified the malnutrition which had complicated the picture.

A 2-year-old child was brought by his mother to the clinic because he had been sick for 2 months. He looked malnourished and chronically ill and showed a fever and swollen glands. The physician, suspecting tuberculosis, recommended diagnostic laboratory work, but prescribed no medication pending blood and X-ray reports. The mother was told that the blood tests and chest X-ray would have to be done at the Weld County Hospital the next day, and that the child should then be brought back to the clinic for treatment. The parents did not take the child to the hospital for the tests. Three days later in the course of a home visit the nurse was told that the family would be leaving the camp in a day or two because of lack of work and had not gone to the hospital because they had no money. Possibly more might have been done for this child if some sort of treatment had been started when he was first seen, or if laboratory work and satisfactory X-ray equipment for young children had been available in the clinic, instead of 25 miles away.

One of the most interesting experiments for migrants in Colorado during the past summer was in the educational field. The school district in Wiggins, in Morgan County, adjacent to Weld County, set up a summer school for migrant children from the end of May to the first week in July, assisted by funds from the Colorado State Department of Education. The children were brought to the Fort Lupton clinic for physical examination and X-ray. While the plan had been to give no injections so that this health experience would be remembered as free from pain, the clinician found five children with inflamed throats and elevated temperatures and ordered penicillin for them. However, a local church group had supplied ice cream and cookies which were served at the end of the clinic, so that the children left smiling. The county public-health nurse gave the subsequent injections to the children needing them, and with the medical social consultant followed up with home visits to the families of the few children who had specific medical problems.

The school program itself contributed to the children's health. It emphasized hygiene instruction by having the children take shower baths, brush their teeth, and wash their hands. A bountiful and well-cooked hot lunch was served every day, including a large proportion of protein foods and milk. Through the help of the local PTA, this was available to all the children, whether they could pay the fee of 20 cents or not. Doubts about the acceptance by Spanish-speaking children of Anglo food were resolved by the way these youngsters attacked the lunch, and particularly the way they all drank milk. Figures for weights and heights which were recorded at the beginning and end of the school term show that the children during this period gained as much in both height and weight as would be expected during a period of 6 months for Anglo children in Colorado of the same ages and on an adequate diet.

Evaluation and Plans

In the beginning of the program the many groups in the two counties touching the lives of migrants knew little of each other's purposes and resources. Complete understanding can hardly be expected to be accomplished in one season but the progress has been encouraging. From the very first, representatives of the county welfare department, the local employers' groups, the State employment service, the Mission to Migrants of the National Council of Churches of Christ in America, and the Girl Scouts of the U. S. A., as well as of the local health departments and the local medical societies, were brought into the planning. In Mesa County an advisory committee on migrants representing these groups was formed which will continue to function in the coming season.

At the end of the season meetings were held in both Mesa and Weld Counties to discuss the summer's experience, to attempt to evaluate the strengths and weaknesses, and to plan for another season. In both areas the programs were considered definitely successful. The consensus was that the health needs of the people in the camps had been handled earlier and more smoothly than had been the case in the past, and complications had thereby been reduced. Members of the medical profession in both areas were pleased at being relieved of some unnecessary and minor work. They used the help of the public-health nurse more effectively as they became familiar with it.

Relationships and communications between local agencies had clearly improved as these agencies

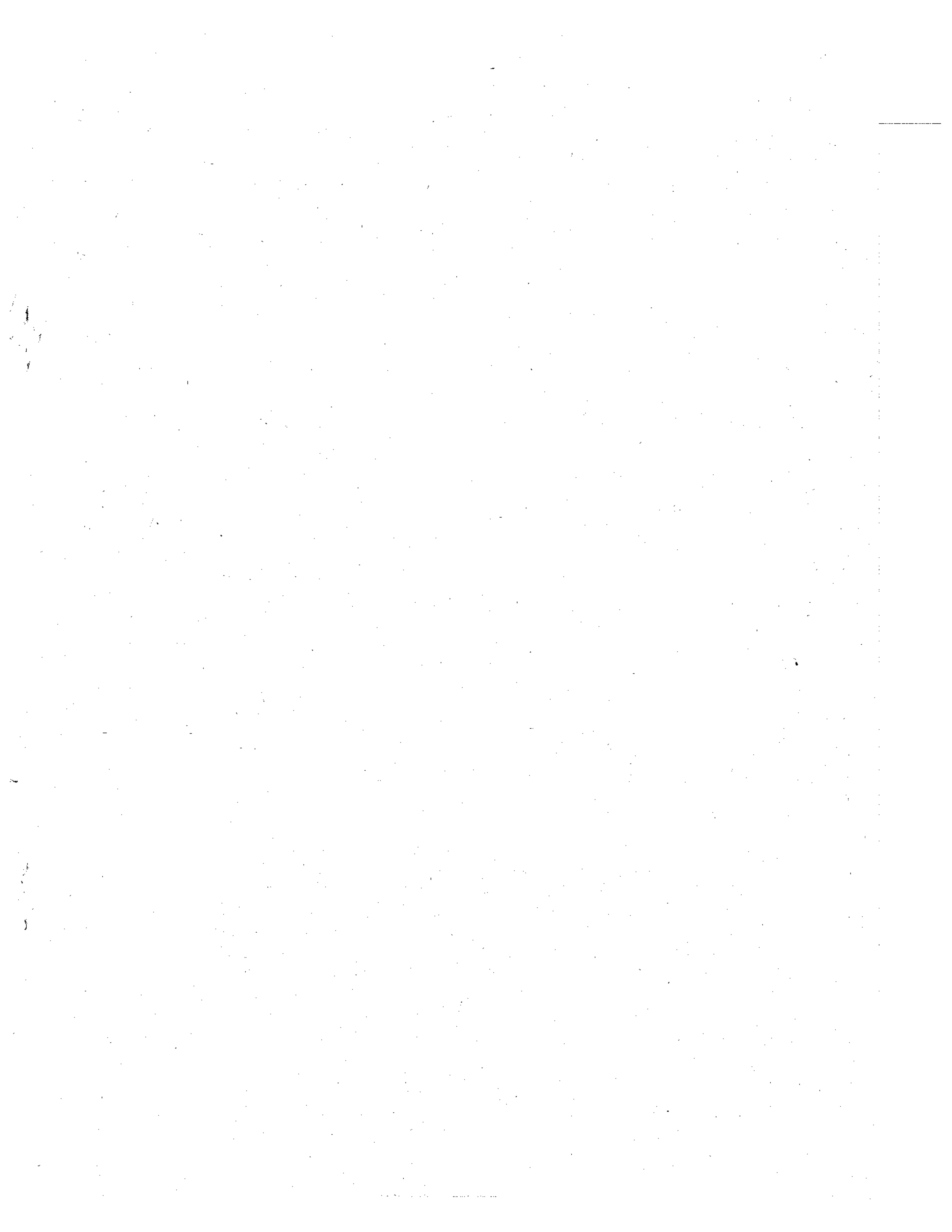
learned more about each other's functions and resources. In Mesa County, where the nursing staff had worked closely with the representatives of the peach growers and had made contacts in the community, an excellent relationship had been established which was reflected in better understanding of the local health department.

Both communities have expressed the wish to have a similar program next year and have suggested few changes. They do not seem as much concerned as the staff members of the State health department over certain definite shortcomings in last summer's program. While it was obviously essential to begin at the focal point of local interest, the camps, these programs did not serve the migrants throughout their respective counties nor even throughout the major part of the counties. Few of the migrants living in the small camps elsewhere in the counties or on the ranches sought them or even knew about them. Next year there will be a campaign of publicity to inform the employers, ranchers, and other interested groups throughout the county earlier and more completely as to the services they can expect for their employees. The public-health nurses will cover a wider area and a social worker may be attached to each project for the summer season.

One of the first steps in setting up the last summer's program was to design record forms, with the assistance of expert consultants from the Children's Bureau and the Public Health Service. This proved to be an exacting task, since it was essential that the records be readily usable by the local personnel in various situations and still serve as effective channels for the transfer of information to other agencies within and without the State. These forms proved useful in operation, but some important changes must be made if they are to form the basis of a widely used record system. More thought must be given, particularly to the means of transferring brief essential information about a patient or a family from one area to another, either with the family or speedily upon request.

The summer's experience has nevertheless confirmed our faith in the principles on which the local projects for migrants were set up. Other areas in the State are now expressing an interest in making some health plan for migrants for the coming season. In working with them we shall be even more acutely aware that to perpetuate itself a local program must be so oriented that it can eventually become part of the health services available to all residents of the community throughout the year. Hence, it must take into account the economic facts of life; it must enlist wide local interest, understanding, and support; it must recognize the cultural attitudes both of the migrants and of the community and must make definite efforts to resolve the differences between them; and, because the flow of migrant labor is governed by the variations of growing seasons, it must always be flexible.

To further strengthen the program, we have been working this winter on efforts to improve communications with everyone concerned with the health of migrants—in all levels of agencies and in communities both in Colorado and at the migrants' points of origin and destination. We have also been trying to consult with as many interested groups as possible on methods of improving the record forms, with particular emphasis on their use in referring patients from one service to another. Eager to cooperate in any moves toward regional planning, we are continuing to advocate the formation in Colorado of a State committee on migrants, concerned with transportation, employment, working conditions, education, health, housing, and other social problems. With such a committee and with the State structure properly integrated with a regional structure, we believe that health services in local areas can be so developed and fitted together that migrants and local families alike can receive the care they need.



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