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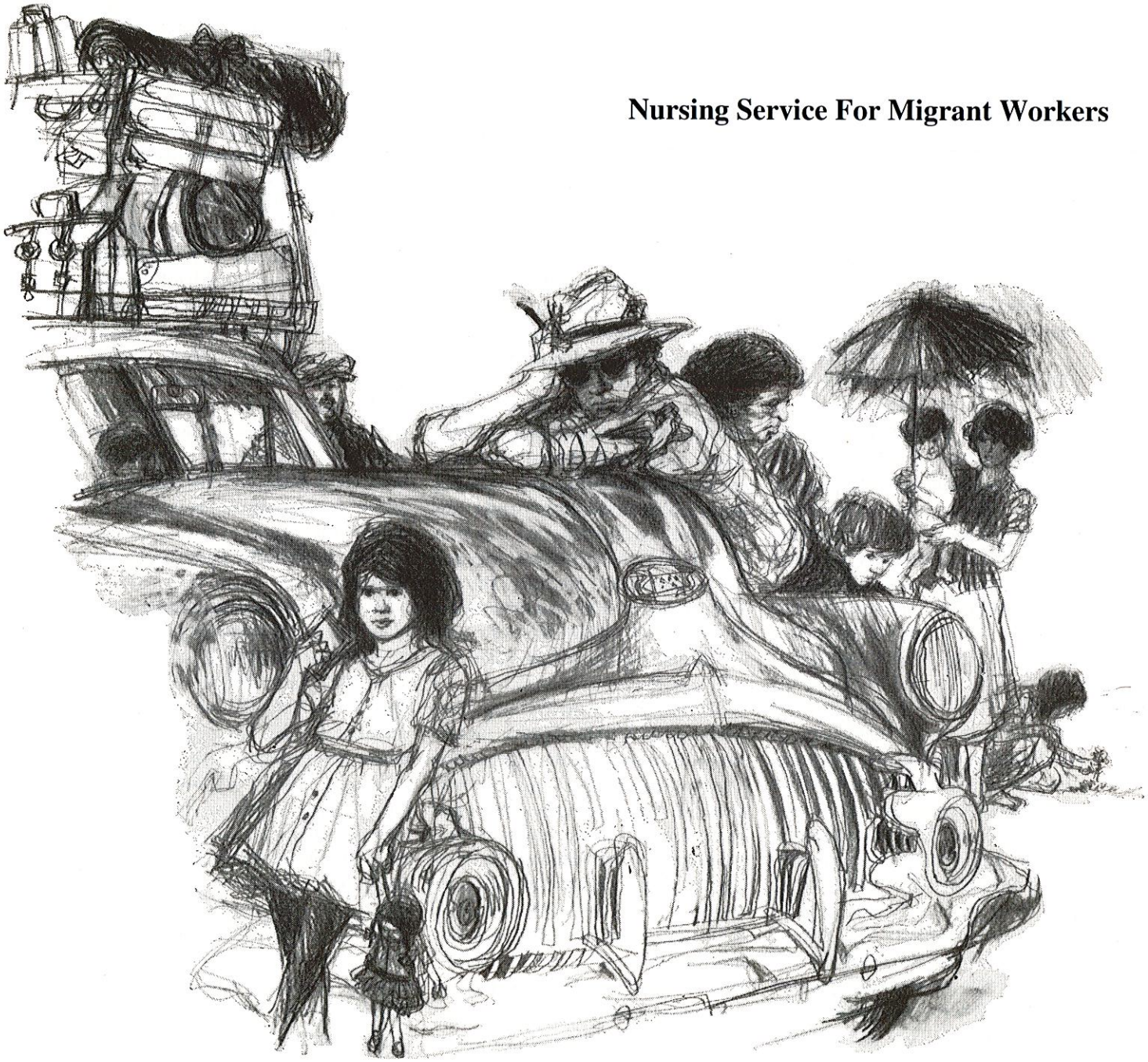

Nursing Service For Migrant Workers

Concerned about the misery of the migrant workers who come to Wyoming's beet fields each year, the state department of health decided to offer public health nursing services within one county. The accomplishments were notable—but so were the frustrations.

MARIAN CHLADEK

The term, migrant worker, as we know it today was probably not familiar to Thomas Carlyle when he wrote:

It is not to die or even die of hunger that makes a man wretched. Many men have died. But it is to live miserably and know not why, to work more and gain nothing, to be heart worn, weary, yet isolated and unrelated. [1]

Yet there could be no more apt description of the plight of today's seasonal farm workers.

Each April approximately 1,800 of these workers arrive in one of Wyoming's counties to work in the sugar beet fields until the middle of July. These workers are Spanish speaking people, the majority of them from southern Texas. They come with their families (including everyone from infants to grandparents) in search of a livelihood. Wyoming is their first stop on a summer long trek following the crops. They come with the hope that this year they will earn enough money to sustain life, buy a new set of tires and, hopefully, have enough left for the necessities of life during the long winter months at home when there are no crops to harvest.

Since it is necessary that everyone over 14 years of age work in the fields if the family is to earn enough money to fulfill these expectations, they come as family groups, sometimes as many as 12 or 14 in a five- or six-passenger vehicle. For them the trip of over 1,000 miles does not include stops at restaurants or motels. The family budget or meager travel allowance, sometimes advanced by the factory recruiter, barely covers their gas, incidental car repairs, and cold lunches.

April weather in Wyoming is a sharp contrast to the warm climate of southern Texas. Though many of these families have made the same journey year after year, they are never prepared for the drastic change in temperature. Their need to earn a livelihood and their hope that this year's weather will be better keeps them coming in spite of their inability to provide themselves with suitable clothing or travel money. Because of fatigue, inappropriate clothing, crowding, and nutritionally inadequate food, there is always an immediate siege of upper respiratory infections, intestinal upsets, and diarrhea on arrival at their destination. This condition, referred to as "shipping fever" by the county health officials, affects most severely infants, preschool children, pregnant women, and the elderly.

Since this condition is more or less expected, they seek medical care only when they become truly frightened of impending death, and all home remedies have failed. Consequently, emergency visits to the physician occur at all hours of the day and night and, frequently, the patient is taken directly to the hospital because families do not know how to locate a physician. These families, without financial resources and friends, are ineligible for welfare aid because they do not meet residence requirements. To further complicate the situation, this county had no public health services—that is, no local health department, public clinics, or public health nursing services.

Staff members in the Wyoming Department of Public Health heard stories of teenagers with terminal tuberculosis who had to return to their place of origin for care, of infants dying in the fields, and of children suffering from malnutrition. To learn more about the situation in this county, in the summer of 1962 members of the department held conferences and exploratory interviews with the local health officer, growers, factory personnel, welfare workers, and the hospital personnel. These interviews revealed reactions ranging from concern to apathy, as well as suspicion of our "sudden interest," but not many facts. In order, therefore, to secure reliable information regarding the illnesses of the workers and their families, we asked the hospital to keep a record of admissions, diagnoses, ages, and length of hospitalizations of the migrant families. From the hospital records for the 1962 and 1963, and 1963 and 1964 seasons, we learned that about 50 percent of the patients admitted to the hospital were under 21 years of age, and approximately 25 percent of the total admissions were for pregnancy or conditions related to pregnancy. There were several deaths each year; in 1963 the two deaths occurring in the hospital were of infants—one a newborn, cause of death undetermined, and the other a five-month-old infant with gastroenteritis.

NEW NURSING SERVICE

After our initial exploration of the situation, we in the Wyoming Department of Public Health asked ourselves what we might do to help migrant workers cope with their health problems. Evening clinics, along with the employment of a public health nurse and perhaps a clinic nurse, were suggested. The clinic was not acceptable to the medical society. However, the physicians agreed to our proposal to employ a public health nurse to work with the migrant families during their stay in the county.

Because the physicians in the community were not accustomed to public health nursing services, we were asked such questions as: "How will the public health nurse work with these families and be received in their homes without the aid of a law enforcement officer?" "How will the public health nurse instruct these families without an interpreter?" We asked ourselves, "How can one nurse make a meaningful and effective con-

[1] CARLYLE, THOMAS. Past and present. In *Book 3; the Modern Worker.* New York, Harper and Brothers, 1843, Chap. 13. Democracy.

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tribution to the health of these workers and their families in the short time that they are in this country?"

Our other concern was that of recruiting a nurse interested in short-term employment. It seemed almost a miracle when a well-qualified public health nurse, who classified herself as a migrant because her husband was employed in construction, came to our office to inquire about opportunities in public health nursing. She was interested in this project and we employed her.

After a week's orientation in the Wyoming Department of Public Health, the public health nurse, armed with her bag, an ample supply of Zephiran Chloride Towelettes (because there is no running water in most of the homes), abbreviated health record cards, and enthusiasm, left to take over her assignment. Her first task was to introduce herself to the county health officer, the other physicians, the welfare workers, the factory officials, the field placement men, the hospital administrator, and the director of nurses. The public health nurse was offered space in the director of nursing's office for her headquarters. This proved to be a most fortunate arrangement.

CASE FINDING

One of the many questions asked of the public health nurse at these introductory visits was, "How will you find the families in need of medical and nursing services?" Although at the time she did not know all the answers to this question, she did have a few ideas of how she would locate and work with the migrant families.

The public health nurse began by attempting to visit all of the migrant families as soon as possible. She learned their names and the locations of the farms where they were placed from the labor placement field man at the factory. She visited him daily for the first three or four weeks. In addition to giving her this information, this field man made a quick survey of all new arrivals and reported to the nurse those families which, in his opinion, required urgent nursing care. During her visits to the families, the nurse found that almost all of them had health problems, ranging from minor to very severe.

"Visiting" the families did not mean knocking on the door and taking a survey from the doorsill. It meant sitting down and talking with the family members often for one to one-and-one-half hours. The nurse found that having the family help her complete the health record served as a good method of breaking the ice. Recording the birth dates and names of each member of the family served as a conversation bridge to worries and concerns relating to illness and feelings of hopelessness about inability to obtain needed medical care.

Thus, the usual answer, "No speak English," though almost always the first reply to the nurse's initial introduction, did not prove to be a handicap to the public health nurse. She learned that when she sat down in the home and took sufficient time for the social amenities so important to a person of Spanish-American culture, it was not long before the entire family became involved in discussing their health problems. Only rarely did the nurse have to ask one of the resident Spanish-American women to act as an interpreter.

Because the public health nurse used the hospital as her headquarters, her working relationships with hospital personnel and physicians were facilitated. The public health nurse visited the hospitalized patients and obtained orders for medical follow-up from the physician and for nursing care from the nursing staff. She also visited all of the physicians' offices at least once a week to report on families she was caring for and to receive new referrals.

She had additional case-finding methods. The Catholic priest and sisters who conducted religion classes for the migrants' children sought out the nurse to tell her of families with health problems. Then, too, as the migrant families became accustomed to the nursing service, they asked the nurse to call on friends, relatives, or acquaintances with health problems.

It was evident to the public health nurse after her first week on the job that finding patients was not a problem. Her chief worry now was how to provide all the care they needed. However, not all the families had serious problems. Many of them just wanted to talk to the nurse, because she was someone who understood and sympathized.

FRUSTRATIONS are sometimes the lot of the nurse caring for migrant workers.

The following two case examples are excerpts from the public health nurse's reports and they illustrate both the satisfactions and frustrations in working with a highly mobile population:

Mr. R., aged 44, is heavyset and has a ruddy complexion. He was diagnosed as having diabetes two years ago. He started taking insulin but apparently the dosage was not well established, because he said it made him dizzy and he could not see, so he discontinued it. He said he was taking "diabiness" twice daily, but the bottle he showed me was still sealed. I tried to impress him with the importance of good medical care, diet, and medication, but he just gave me an impish grin. I believed he was ignoring his diabetes and me, too.

Four days later while visiting the hospital, I learned that Mr. R. suffered a stroke en route to work and was admitted to the hospital. His blood pressure was 280/110 mm. Hg. He seemed quite relaxed when I visited him on this date.

One day later: Mr. R. is very apprehensive. He is having difficulty swallowing and some weakness of his right leg, and he needs a great deal of reassuring.

Two days later: Mr. R. feels better today. He still has difficulty swallowing but, with mischief in his eye, he asked if I remembered telling him he should be sure to take his two pills every day. I said I remembered. He said, "I say I do; I don't. Now, I do."

One day later: Mr. R. asked to be released from the hospital. The physician does not think that he can force him to stay, although the family plans to leave the area the following day to go to Oklahoma. There will be six grown people in a passenger car, and Mr. R. has not even been out of bed. His blood pressure is down to 160/90 mm. hg. He does not look good and has a persistent, productive cough. With the help of an interpreter, I tried to persuade Mr. R. to remain hospitalized for a few more days. His only answer was that he would discuss the matter with his family.

Baby girl Maria (age five months) is the youngest of six children. The oldest is seven years old. I visited this home on one of my case-finding visits and found this patient ill with a temperature of 103° F. I asked the mother about the baby's prior health, how long she had been sick, but could not get satisfactory answers. I urged the parents to take the infant to the physician immediately. About two hours after I had been in the home, the baby was admitted to the hospital by a local physician. She was dehydrated, anemic, and suffered from malnutrition, along with severe diarrhea.

The physician asked that I go to the home for follow-up when he dismissed the patient, after three days of hospitalization. Not knowing whether the cereal which the physician had prescribed would be in the home, I took some with me from the hospital. As I anticipated, there was no cereal in the home, but only several containers of baby fruit (so often this is the first solid food offered these infants). Questioned about the infant's diet, the mother said that the baby would not take cereal. However, I prepared the cereal and fed the baby several mouthfuls which she swallowed readily. The mother, on my suggestion, continued to feed the cereal to the baby. Baby Maria ate the entire cupful and immediately went to sleep. This demonstration, along with instruction to the mother and to the half dozen or more family members, on the infant's daily diet needs apparently was understood because, when I returned to this home after several weeks, the infant had gained weight, her skin tone was good, and she had no adverse symptoms.

ACCOMPLISHMENTS

The friendliness, appreciation, and acceptance of the migrant families made this a highly motivated and personally rewarding nursing assignment. Nevertheless, the experience was frustrating for a variety of reasons. The concerns of a nurse working with the migrant family are the same as those of a public health nurse working with resident families, except the nurse working with a resident population is able to make a nursing plan and set realistic goals.

The nurse working with migrant families, however, does not have this satisfaction. These families move on and are never quite sure of where they are going—it might be Michigan, Minnesota, or Oklahoma. Referrals to other health departments, public health nursing services, or physicians are practically impossible, because so little is known about facilities in the areas where these people might go. Consequently, the public health nurse is left with the questions: "What happened to the two patients with acute rheumatic heart disease, with only a three-month supply of penicillin? Are they still under a physician's care? Are they still receiving the necessary prophylaxis? Did I really interpret sufficiently to the family the need for continued medical supervision?" Similar questions could be asked regarding practically each patient the nurse had in her case load and had visited, at the most, three to four times, during his short stay as a migrant worker in Wyoming.

In spite of these frustrations and unanswered questions, we believe the public health nurses did make meaningful and effective contributions to the health of the agricultural migrant families in this county. There are several reasons for this conclusion. First, the Wyoming Department of Public Health was again asked to employ a public health nurse for the 1964 season. Second, the public health nurse was welcomed into the homes of the migrants and in most instances they followed her teachings and recommendations. Third, the physicians reported that in the second year (1964) migrants improved in observing office hours and came more often before conditions were serious. Finally, there were no deaths in the 1964 season.

In June 1964, a group of representative citizens met with the county commissioner to ask that funds be appropriated for a full-time public health nursing service. County and city officials did appropriate a budget for this service and on the request of the county officials, the Wyoming Department of Public Health recruited a public health nurse, and full-time service began on November 1, 1964.

MARIA'S MOTHER LEARNED from the nurse how to remedy the baby's malnutrition.