ORIENTATION TO MULTICULTURAL HEALTH CARE IN MIGRANT HEALTH PROGRAMS

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INTRODUCTION

> *"For those who want to practice medicine, dentistry or nursing where their efforts will make a major impact, rather than a minor ripple, it would be difficult to find a more interesting, challenging, or rewarding arena than that found in migrant health . . . ."*

The process of sensitizing health care providers to the distinctive issues involved in delivering services to migrant farmworkers is an ongoing, time-consuming, and worthwhile task for migrant health programs. In order to facilitate and structure this process, the Migrant Clinicians Network and the National Migrant Referral Project, Inc., participated in the development and dissemination of Dr. Robert Trotter's guide, *Orientation to Multicultural Health Care in Migrant Health Programs.*

The purpose of this orientation guide is to furnish health care providers serving the migrant and seasonal farmworker population with information in order to cope with the complexities of health care delivery in a multiethnic, multicultural environment. The concepts presented can be directly applied, will improve patient compliance with therapeutic regimens, and will help minimize frustrations for both clients and staff.

This guide weaves the themes of respect, caring and concern throughout its text.

Section I provides an introduction to basic cultural concepts which influence the outcome of interactions between providers and their migrant patients.

Section II describes the migrant streams and delineates background information on pertinent aspects of the migration cycle and the migrant lifestyle.

Section III details the health characteristics of the migrant population which create the distinctive requirements for health care delivery.

Dr. Trotter's guide can be used independently in orienting staff who are new to the migrant health delivery system. It can also be used as a companion guide to an audiovisual orientation produced by Claire J. Waring entitled, *The Road to Quality Migrant Health: The Importance of Sensitivity and Respect for Lifestyles and Cultures.* This one-half hour introductory videocassette is available for purchase from the National Migrant Referral Project, 2512 South I.H. 35, Suite 220, Austin, Texas 78704.

I. An Introduction to Culture and Health Care

Knowledge and tolerance of cultural diversity is integral to effective health care delivery. A culturally-relevant perspective helps explain, cope with, or prevent behavior that would otherwise be unexplainable or disruptive to the routine process of primary health care delivery. Cultural skills are especially useful in helping the health care professional communicate with people who have a different lifestyle and a different cultural background from that of the provider.

Knowledge and tolerance of cultural diversity is integral to effective health care delivery.

This introduction seeks to furnish information to health care providers serving the migrant and seasonal farmworker population to help them cope with the complexities of health care delivery in a multiethnic, multicultural environment. The concepts presented can be directly applied, will improve patient compliance with therapeutic regimens, and will help minimize frustrations in delivering health care.

The Concept of Culture

Culture is the social glue that holds human relationships together. It is the mechanism by which we share our understanding with one another and understand other people. There are two ways of looking at culture that may be useful within a health care setting. One way views culture as a behavioral map; the other describes culture as a perceptual filter.

Culture provides us a mental survival map.

1. Culture as a Behavioral Map

Each of us carry a general "map" of human relationships for our own society. Each "map" is called culture. Like a geographic map of another territory, a cultural map lets us know where we are in relation to everything else.

Culture as a behavioral map can provide general rules for interctions with and value clarifications about other people.

Instead of providing a physical map of a territory, culture provides us a mental survival map. As with using a road map, we can travel throughout life knowledgeable of where we are in relation to where everyone else is. Like some maps which forfeit specific details in order to portray a large area, culture may only provide general direction. But, for the sake of the analogy, it is possible to find detailed "maps" for specific kinds of behavior when necessary.

Culture as a behavioral map can provide general rules for interactions with and value clarifications about other people. It is learning to behave as others expect behavior to be. As a map, culture determines the boundaries of relationships between males and females, between old and young, between the powerful and the powerless.

Differences in behavioral maps can cause the same kind of reaction that would occur as when driving a car on the sidewalk instead of the street. Even though the direction is the same as other cars, this behavior is irritating to or endangering others.

Within a single culture, most people share most of their maps, most of the time. Severe problems can occur, however, between individuals of two different cultures, where the maps may be radically different. We can lose our bearings when we are put in an unfamiliar culture. New maps can be learned, in time, but the process is long and can be hazardous.

Lack of familiarity is a problem faced by patients of different cultures when they enter a medical setting. The patients' maps may not fit, and they may be seriously endangered if they have to take time to learn a new one. In the interim, health care providers need access to someone who is knowledgeable of both cultures, or who is at minimum, sensitive to the problems and processes of cross-cultural healing.

For a patient with a different social, cultural, racial, or ethnic background from that of a provider, it is best to assume that the behavioral map of the patient and the provider will be out of sync. Differing expectations about how each person should behave may exist, and the provider must therefore be alert to the possibility for miscommunication. This is an especially sensitive issue when cultural differences about modesty arise.

2. Culture as a Perceptual Filter

When using a camera, it is possible to drastically alter the way reality is captured on film by imposing different kinds of filters in front of the lens. The appearance of reality is changed by altering the light entering the lens. Reality has not changed, yet the perception of it does. Culture serves the same function for individuals as a lens filter does for a camera.

Culture serves the same function for individuals as a lens filter does for a camera.

Each culture is selective in what is filtered out and what passes through into human consciousness. Some things pass through unchanged, others go through subtle shifts in emphasis. Elements prominent in one culture may be missing entirely from another.

The filter effect of culture has great impact in the area of communication. Communication from one language to another is facilitated when both have the same concepts. This allows for literal translation. Communication becomes more difficult when there is no correspondence between words in one language and those in another. If two cultures share enough of their basic concepts, this problem can be overcome by idiomatic translation. Miscommunication, however, can easily arise when concepts in one language do not even exist in another.

Culture, Reality and Ethnocentrism

Culture defines reality and becomes the only window through which reality will be perceived.

Culture is a learning process which begins in infancy and continues throughout life. During this learning process, continuous modification of both the perceptual filter and behavioral map occur. Previously learned elements of the culture are reinforced at each life stage. The result is that once learned, culture defines reality and becomes the only window through which reality will be perceived. To attack someone's culture (their language, their beliefs, their behavior) is to attack the person's innermost self.

Ethnocentrism: the belief that one's own culture is superior.

Culture creates a shared reality among the members of one group, and at the same time creates barriers between groups. Behavior or beliefs that differ define other people as outsiders, as deviants, or even as nonhuman. This is ethnocentrism: the belief that one's own culture is superior to others.

Within a culture, ethnocentrism has the positive effect of reinforcing individual identity and group cohesion. It allows for commonality of purpose, the development of codes of ethics, and effective communication between individuals. Between cultures, however, ethnocentrism causes judgements of "different" to be equated with judgements of "inferior".

Within the context of a cross-cultural clinical encounter, ethnocentrism can prove detrimental to patient health care. Miscommunication and a lack of cultural sensitivity can cause a breakdown in one or more of the critical elements in delivering optimum health care to culturally different populations.

If patients cannot understand what they are told, they are unlikely to do what they are asked.

The most frequent breakdown is in the area of compliance with a prescribed treatment: if patients cannot understand what they are told, they are unlikely to do what they are asked. If what they are told offends them, they are even less likely to comply with recommended treatment. Here, perhaps more than anywhere else, communication and understanding are critical.

Language and Communication

Communication forms the basis for effective health care. It is important to try to ensure that the people receiving health care are spoken to in their own language. If the health professional and the patient cannot communicate, clinical encounters may be effective in some situations, but are guaranteed to be more difficult and create problems such as noncompliance or recidivism.

If the health professional and the patient cannot communicate, clinical encounters are reduced to the level of veterinary medicine.

There are several levels of communication in health care settings. The ideal would be for provider and patient to share both a social language and a sophisticated understanding of modern medical concepts. This level of communication is rare. More frequently, a patient and practitioner will share social languages, but will have communication mismatches during clinical discussions.

A nurse asked if a hospitalized patient had urinated. The patient responded "no". After the same question and answer had been repeated over the course of the day, a physician ordered a catheter for the patient. When the nurse brought it in, the patient protested that she did not need the catheter because she had peed three times that day. When the nurse retorted that she had repeatedly asked the patient if she had urinated, the patient told the nurse that she didn't know that word and would have responded differently if the nurse had asked her if she had peed. The nurse had avoided the word because she considered it unprofessional and because it offended her concept of modesty.

The problems of communicating are multiplied when patient and professional share neither a social language nor a clinical

language. This situation is found frequently in migrant health centers, where patients may be monolingual in Spanish, Haitian Creole, Vietnamese, or a Native American language.

While respect, caring and concern can be communicated nonverbally, clinical encounters may require translation.

While a lot can be communicated nonverbally (such as respect, caring, concern), a need often arises for specific verbal communication in primary health care service delivery. These situations usually require translation. Using a translator in a clinical encounter takes skill on the part of both the health professional and the translator.

A 70-year-old man who spoke only Spanish was hospitalized. The nurse on the shift spoke only English and asked a bilingual aide to translate because the patient needed to be catheterized. The nurse told the aide to tell the patient that while inserting the plastic tube there may be some discomfort, but that the patient would be okay as long as he did not thrash about. The nurse also asked the aide to tell the patient not to move about, or he might pull out the catheter. The catheterization occurred in the late afternoon. The next morning a bilingual nurse found the patient in considerable distress, exhausted, rigid and shaking in his bed. In questioning the man about his distress, the nurse found out the patient had thought the aide had said to not move because the catheter might break. Thinking the catheter was glass, the patient had remained awake and rigidly immobile all night to avoid breaking it. Here, conceptual transfer had not been complete.

A common error in a clinical encounter is to select anyone who speaks the language, and ask them to translate.

One problem in translation is using someone who has not been trained in conceptual transfer of information. Since no two languages are identical, the translator has to make sure that a conceptual transfer, not just a literal translation, has been made. In a clinical setting, the transfer is often from technical clinical concepts in one language to acceptable social terminology in a

second language. This means that the translator must know the technical concepts, preferably in both languages, and know how to change them into terms that the patient will understand.

In clinical encounters involving translation, it is essential to determine whether patients understand words in the same way they were intended when spoken. When asked if they understand a specific point, patients will often automatically respond "yes" even if they do not understand the information at all.

To ensure that patients understand, ask them to repeat back, in their own words, what they have heard.

Most cultures have strong sanctions which impel its members not to appear foolish or ignorant in public, especially in front of children. So, people's responses may be polite rather than truthful from fear of appearing ignorant if they responded "no" when directly asked if they understand. An indirect approach is often more effective.

A Hispanic child had a serious but operable congenital heart defect. The probability that the child would be able to lead a relatively routine life after the operation was 95 percent; the risk of failure was 5 percent. If the child did not have the operation, the prognosis indicated that the child might only live to the age of 12. Much to the distress of the clinic, the child's family decided against the operation. It was only after the operation was no longer possible that, during a follow-up visit, it was discovered that the family had "heard" that the operation was 95 percent fatal. Because of the parents' lack of sophistication in dealing with probabilities and their love for their child, the parents had decided that a guaranteed 12 years of life was better than only a 5 percent chance of the child living through the operation. Upon further investigation, it was discovered that slight differences in how statistics should be expressed in Spanish may have led to a translational breakdown in communication.

When it is vital to know if patients have understood, it is important that they be asked to repeat back, in their own words, what they have heard. Again, the goal is conceptual transfer, and success can only be assured when there is sufficient feedback which proves that the transfer has taken place. Careful translation can extend the time it takes to provide care to a patient, but it can eliminate repeat visits and even avoid tragedy.

Respect for Cultures and Individuals

Showing respect for individuals and their cultures is the single-most important characteristic that must be demonstrated in multicultural health care settings.

It is not always possible for health care providers to speak the languages of all patients in a center. It is possible, however, to control one's own attitudes toward people and how those attitudes are expressed. Tenured staff members of multiethnic centers recommend that health care professionals continuously show respect for each patient and for each patient's culture.

Respect is an action, not just a belief.

Respect is easy to recommend, but more difficult to demonstrate. Most of us believe that we show respect to individuals, even when there is evidence to the contrary. Most of us believe that we show respect to other cultures, even though we may disagree with some elements of or not understand the culture. Respect is an action, not just a belief. Behavior demonstrates respect far more powerfully than words.

Language differences may unintentionally demonstrate disrespect.

When patients are surrounded by others who are speaking an incomprehensible language, they may feel that they are being talked about, being made fun of, or somehow being belittled. This feeling can be especially acute if a person is in an emotionally tense setting, such as in a clinic. One form of disrespect occurs when providers talk to one another and not to a patient. This indicates to patients that they are something to be talked about, rather than someone to talk with, as if they were either not there or incapable of understanding what is going on. Even if the cause was unintentional, the effect of disrepect is one which impedes effective health care delivery.

In most cultures, haste is perceived as a form of disrespect. Providers in migrant health centers are under constant pressure to be efficient. To not take the time to deal with a patient as a person, however, is one of the most convincing ways to convey disrespect. In general, the U.S. cultural system stresses efficiency above personalization; the converse is true in most other cultures. Regardless of the duration of a clinical encounter, patience combined with sincerity, can result in patients' feeling that there has been no haste, no disrespect, because they were the focal point of the contact.

In general, U.S. culture stresses efficiency above personalization; the converse is true in most other cultures.

Condescension is extremely disrespectful in all cultures, yet there is an unfortunate tendency toward this when professionals are trying to explain technical conditions to someone from a different cultural background. Too many health care providers unintentionally speak condescendingly to patients. Instead of changing medical concepts into nontechnical adult concepts, these are changed into overly simplistic pictures better suited to a child. Even through the filter of translation, this type of behavior is transparent, because condescension is conveyed by **how** something is said rather than by exactly **what** is said.

Condescension is extremely disrespectful in all cultures.

A fluently bilingual physican used four crude clay cups to explain the function of the heart to his pediatric patients. He would stack the cups, and then describe each cup as being a room in a little house, with connecting doors. He talked about blood going from room to room, about problems from holes in the walls being in the wrong place, and about problems from doors not working correctly. This technique worked well with children. Unfortunately, he used the same technique with parents even when they had been present during his talk with their child. He also occasionally used Spanish diminutives with the parents, which are used when talking to children. He seemed unable to make the shift from little houses to more appropriate and useful analogies for adults, such as pumps or motors. The physician also regularly provoked a hostile reaction from the parents, who were in a stressful setting and anxious about their child's heart problems.

Perceived insincerity may also pave the road to negative reaction. Certain types of emotions are readily detectable between cultures, even when language barriers exist. Sincerity and caring come through loud and clear and provide an emotional atmosphere in which the patient will cooperate even though other conditions may be less than ideal. Insincerity, condescension and disrespect also come through equally loud and clear and may directly interfere with the medical encounter.

Sincerity and caring come through loud and clear to patients.

A manifestation of disrepect occurs when mixed cultural signals are given to patients. Both the individual and the individual's culture must be shown respect, not just one or the other. Demands that patients change their eating habits exemplify this, as nothing is more of a cultural indicator than food. Regardless of how much individual respect is shown, telling patients they cannot eat something which is a part of their staple diet, is asking them to isolate themselves from their cultural identity, from what "real" people eat.

Both the individual and the individual's culture must be shown respect, not just one or the other.

Here, respect-related problems stem from conveying to patients (through actions or words), that their beliefs, knowledge or behavior are inappropriate or harmful without providing a culturally-palatable reason for the message or a culturally-appropriate alternative behavior that fits their reality. Instead of changing their cultural beliefs and behavior, patients may instead change practitioners. If they cannot go somewhere else, they may ignore part or all of the practitioner's advice.

Disregard for a patient's own input into a clinical encounter is disrespectful to that individual. In most cultures, people are expected to provide an opinion regarding their own illness, and they expect that these observations will be treated seriously. Failure to solicit patient opinion implies that their own ideas about an illness are meaningless.

Perceived disrespect for patient opinion may be in direct proportion to a patient's reaction of anger or distrust toward a professional.

The time taken to obtain patient opinion may be as useful as a clinical test to diagnose a health condition. Perceived disrespect for patient opinion may be in direct proportion to a patient's reaction of anger or distrust toward a professional.

Disrespect for the patient's input is also shown in attacking their opinion. This kind of mistake is made when patients present a self-evaluation of their illness and this opinion is disregarded by a health professional.

Consider the scenario below, with any illness or health problem as stated by a patient.

PATIENT: "Doctor, I think I've got the illness!"

DOCTOR: "Why don't you let **me** worry about what you've got. We'll run a few tests and find out for sure what it **really** is."

Frequently, ideas about disease causation differ widely between the patient and the provider. This is not to say that no attempt should be made to correct improper information which a patient may have, especially where it may interfere with delivering good health care; however, timing is critical. Not all forms of misinformation are immediately harmful, and hasty attempts at correction may be perceived as an attack rather than an attempt to help.

Parallel systems of health care.

Many significant differences in health care beliefs between populations revolve around religious concepts, beliefs in magic, and in rituals. In some cultures these act as adjuncts to modern medicine, especially in their role as positive reinforcement or psychosomatic therapy. Health professionals are rarely told that events related to these beliefs take place. As far as patients are concerned, they are using parallel systems of health care. Patients believe that both systems help them, and that success is guaranteed when both are used together.

The use of folk healers and folk medicines is a sensitive area.

The use of folk healers is an especially sensitive area. A folk healer more often acts as a silent partner and adjunct to a health care professional, rather than a competitor. Folk medicine fills in the gaps where comfort, confidence, and hope cannot be fulfilled through scientific medicine or in modern medical or dental settings.

Many practitioners set aside the folk labels for illnesses, thinking they are either superstitions, or are psychosomatic or behavioral problems.

For years patients have been told that the Hispanic folk illness called *caída de mollera* (fallen fontanelle) was imaginary and not a real illness. Whether patients presented it to Anglo or Hispanic physicians, they were told "not to bother the doctor with superstition and nonsense." So, people stopped telling physicians their children had *caída de mollera* since they knew doctors did not believe in it. But the problem continued to be treated as an illness in the home.

Now it is known that *caída de mollera* is the folk label for severe dehydration and possibly acidosis in infants. Use of this folk label is a good indicator of an illness and that a child needs immediate medical attention. Patients may not recognize symptoms of dehydration, but they do recognize caída de mollera.

Unfortunately, because of preceding denigration and lack of acceptance of the folk-labelled illnesses, migrant health providers may not get these types of cultural clues unless they demonstrate a willingness to listen to both the patient and to the patient's culture in a respectful way.

To get a patient's cultural clues, demonstrate a willingness to listen to both the patient and to the patient's culture in a respectful way.

Showing respect for individuals and their cultures has repeatedly been identified as the single-most important characteristic that a health care professional must demonstrate in a multicultural health care setting. Unfortunately, one of the common causes of noncompliance with clinical treatment in these settings is a perception of disrespect.

Responsibilities of Providers

The primary responsibility of health care providers is to furnish the highest quality health care to their patients. Beyond the constraints imposed by lack of available time, facilities, and financial resources, there are certain nonmedical responsibilities that directly affect the quality of care.

1. Involving the Family

The cultural groups which are predominant in migrant farm work place a premium on the family unit. This means that the majority of treatment in migrant health centers, and especially the treatment of children, will involve the family, whether or not the provider is aware of this involvement. Family decisions, including compliance with therapy, are not solely made on the basis of an individual's needs, but on the needs and the resources of the entire family group.

To help ensure compliance with a patient's treatment, involve the entire family.

The best way to assure compliance with a patient's treatment is to make sure that the entire family is involved in the process. With a child's treatment, it is crucial to involve both parents.

2. Utilizing the Whole Migrant Health Care Team

Migrant health centers function because there is a team of people who cover all aspects of delivering care to migrant families. No

one individual can or should try to do it all. What is unique about this team approach is the way migrant health centers are structured, and the level of responsibility that staff other than a physician or dentist have for making things work. In contrast to this, many other medical settings expect a physician to organize and direct everyone's efforts.

These functions include transportation, outreach, social services, translation, and transfer of patient medical records. In a migrant health center, with its built-in diversity in cultural populations of patients, staff providing ancillary services may become the most important sources of vital information about a patient's medical or dental needs. They assure that health education needed by patients gets done, and that the providers' recommendations for treatment are followed correctly. These team members are important resources for identifying and solving patient problems caused by misunderstandings or cultural differences.

Migrant health centers tend to function best when they are organized with a team concept which promotes maximum responsibility and respect for each position.

A brief medical or dental examination rarely provides time for successful and in-depth patient education. Health education is better when there is sufficient time to assure that an exchange of knowledge occurs. When education is needed, it can be referred to another team member of the center who has both the time and the cultural background to educate the patient.

3. Avoiding Stereotyping

It is a social responsibility of providers in a migrant health center to avoid stereotyping. There is a very strong human tendency to seek general patterns. This trait is part of the mapping process of all cultures, and is fairly useful since it reduces the amount of diversity that has to be accommodated within a culture. Between cultural, ethnic or racial groups, however, stereotyping is counterproductive.

Stereotyping leads to treating everyone the same, and routinely treating them badly.

There are many counterproductive stereotypes about particular ethnic or cultural groups which include migrants. It takes skill, knowledge, motivation and planning to be a successful migrant farmworker. Season after season, migrants travel hundreds of miles and arrive on time at the field site, in order to work 16-hour days picking the same crops. They could not do this if any negative stereotype was true.

Stereotyping leads to treating everyone the same, and routinely treating them badly. In a migrant health center it is necessary to treat everyone as an individual.

II. Migrant Lifestyles

The economic need, environmental health, and movement of migrants create unique requirements for health care delivery. These lifestyle conditions exacerbate some illnesses and diseases in migrant populations, make others occur more frequently in the migrant population than in the general population, and create special health care delivery problems such as ensuring follow-up and continuity of care.

Migrant farmworkers are modern industrial nomads. Most migrants do not wander from state to state looking for work. Instead, they follow well-established migratory routes, and, barring disaster or extremely unusual conditions, follow the same cycle year after year. This section provides an introduction to the lifestyles of migrant farmworkers and describes the migrant streams, the migration cycle, and specific living and environmental conditions which impact health care delivery.

Migrant farmworkers are modern industrial nomads.

The Migrant Streams

There are three major migrant streams in the United States. Each one has a unique character that effects health conditions and the delivery of health care in that stream.

1.The East Coast Migrant Stream

Migrants in the East Coast Stream have their primary homebase in Florida.

Most migrants in the East Coast Stream have their primary homebase in Florida, with others' homebases located in different south eastern states or Puerto Rico. The migration cycle begins with winter crops in Florida, and moves north along the Atlantic Seaboard ending in New York in the fall.

Cultural groups in the East Coast Stream include Blacks, Puerto Ricans, Haitians, and Hispanics.

There are a number of cultural groups represented by workers in the East Coast Stream. Historically, all of the workers were Black. Southern Blacks from Florida, Georgia, and the Carolinas still comprise one of the Stream's largest labor groups. The East Coast Stream also includes large numbers of Puerto Ricans and Haitians, increasing numbers of Hispanic Americans from the Southwest, and some migrants from the Appalachian region. It is not unusual to visit a migrant health center in the East Coast and hear English, two dialects of Spanish, and Haitian Creole simultaneously spoken.

The primary contractor in the camps is an individual called the crew chief.

While working in the East Coast Stream, migrants temporarily reside in labor camps, which are usually barracks. Some migrant camps house predominantly single males. Often an entire camp will be homogeneous in terms of ethnicity. The primary contractor in the camps is an individual called the crew chief or crew leader. He contracts directly with a grower to supply sufficient amounts of labor to accomplish the tasks needed in working the crops. He, in turn, pays migrants for their labor. Most of the time the crew chief will round up a work force and bring the entire group of workers upstream in a bus. He provides meals and transportation, both of which are routinely deducted from migrants' pay. It is not unusual for migrants working for a crew chief to be strangers with one another at the beginning of a season. It is also not unusual for crew members to drop out and for new ones to be added as the crew moves on to new locations.

The combination of the crew chief's control of transportation and living arrangements, and a lack of strong social ties within a crew, has lead some to accuse crew chiefs of exploitation and abuse within the East Coast Stream.

The predominantly male camps, combined with very limited recreational facilities and social isolation have lead to problems with alcohol abuse, sexually transmitted diseases, and interpersonal conflicts, these are among the health problems presented at migrant health centers.

Alcohol abuse, sexually transmitted diseases, and interpersonal conflicts are among the problems presented at migrant health centers.

2. The Midwest Migrant Stream

The Midwest Migrant Stream has its main homebase in South Texas. Migrants move from the winter crops grown in South Texas into Midwestern states, especially Illinois, Indiana, Michigan, Ohio, and Wisconsin. At the same time, South Texas, which is the largest homebase area in the nation, also sends migrants to both the East and West Coast Migrant Streams.

The Midwest Migrant Stream has its main homebase in South Texas.

The South Texas migration pattern looks like the fingers on the left hand stretched out on a map of the United States. One route, represented by the thumb, hooks from Texas over into southern Florida, where migrants then join the East Coast Stream. The index and middle fingers represent two major migration routes into the eastern (Michigan, Ohio) and the western (Iowa, Nebraska, the Dakotas) sectors of the Midwest. The ring finger represents a route that first travels 600 miles into West Texas, up to Colorado, and eventually into the Washington and Idaho farm lands. The final migration route, represented by the little finger, flows north along the Rio Grande River, and the U. S./Mexico border in Arizona and Southern California, where migrants then enter the West Coast Stream.

The South Texas migration pattern looks like the fingers on the left hand stretched out on a map of the United States.

These routes remain fairly stable in good economic times, but migrants will switch from one to another when some type of disaster eliminates the jobs for a particular branch of the stream. When this happens, there are far more problems for the individuals involved in the switch, because they do not know the area they are going into. They may find work, but they may also overload the existing farm labor system, which is to everyone's detriment.

Hispanic Americans from South Texas are the largest cultural group in the Midwest Stream.

The predominant cultural group in the Midwest Migrant Stream is comprised of Hispanic Americans from the southern part of Texas. The majority of Hispanic migrants in the Midwest Stream are U. S. citizens, not undocumented workers from Mexico. A far smaller percentage (often less than five percent) of the Midwestern migrant farmworkers are from other ethnic groups, although there are some Black and Anglo migrants. Recently, increasing numbers of Southeast Asian migrant workers have also been joining this stream.

The basic migrant unit found in the Midwest is a family, which is accompanied in their travel upstream by additional relatives and friends from the homebase community, including single males. The group is frequently lead by a "truckero." He is called this because he owns the truck that is used to haul both the produce and the labor crew to and from the fields. A large number of the camps where migrants reside in the Midwest are family-based, and house families in small, separate dwellings.

The presence of wives and children, as well as the prevalence of lasting social ties among the primary migration group, creates a significantly different pattern of health problems for migrant health centers serving families in this stream. Problems of alcoholism and sexually transmitted diseases may be less than those found in the East Coast Stream, but are replaced by maternity needs, childhood illnesses, and other complaints of a mixed age and sex population.

3. The West Coast Migrant Stream

The West Coast Migrant Stream has its primary homebase in southern California, with secondary homebase areas located throughout the Southwest. This stream runs northward into Idaho, Oregon, Washington, and other agricultural areas of the western states.

The West Coast Migrant Stream has its primary homebase in southern California.

The major cultural group working the crops in the West Coast Stream are Hispanic Americans from the Southwest, primarily California and Texas. As with the Midwest Stream, there is a small percentage of Black and Anglo migrants and increasing numbers of Southeast Asians working the crops. There are increasing numbers of Mexican Nationals also participating in this stream. Large numbers of migrant workers in the West Coast Stream have settled out in northwestern states, a phenomenon that has also occurred extensively in the midwestern states.

The major cultural group in the West Coast Stream are Hispanic Americans.

The primary migrant units are individual families and some single males. Most own their own car and have higher mobility than individuals and families in the other streams. Farm labor unions have been most successful in the West Coast growing areas, which has changed the dynamics between the growers and migrants. Not all crops have been successfully unionized; wages and benefits vary by region and by the type of labor required. These factors have had a direct impact on the health of migrants, and on their willingness to seek help.

The West Coast Stream is considered the most mobile.

The Migration Cycle

The migration cycle begins at a homebase location, which is usually southern Florida, Texas or California.

The migration cycle begins at a homebase location, which is the winter home of migrants and usually located in southern Florida, Texas, or California. At their homebase location, many farmworkers pick crops that are the same or similar to the ones that they will work on in the north, or upstream. Most farm work is paid on a piecework basis. It literally pays farmworkers to specialize in a particular type of crop because speed and, therefore, income increase with experience.

While a migrant health center may stay busy year-round, its client composition and population may vary as the seasons change.

Once a worker is experienced at working citrus, it is fairly easy to switch to working peaches, cherries, or apples. It is more difficult, however, to transfer those skills with the same degree of speed to lettuce, cucumbers, cabbage, carrots, or other ground crops. In areas with multiple types of crops, a continuous change in the migrant population may result as workers move to other areas to work their crop specialties. For example, in Wisconsin, the group of farmworkers routinely harvesting cucumbers or other ground crops is different from the group that routinely comes in to harvest Christmas trees. This means that while a migrant health center may stay busy year-round, its client composition and population may vary as the seasons change.

Migrants follow regular patterns which, if known and taken into account, can lead to greatly increased continuity of care.

After a fairly short learning period most migrants, led by a crew chief, truckero, or other family group, establish a relationship with one or more growers. As long as the relationship is mutually beneficial, the crew chief or the family group will return to the same location over and over again. In most cases, there is contact between growers and migrants or crew chiefs during the off season to determine when to return, and to have some idea who is or who should be coming. Migrants follow regular patterns which, if known and taken into account by health care professionals, can lead to greatly increased continuity of care.

In family-oriented migrant areas, the whole family migrates. In fact, the decision to migrate or not to migrate is usually based on the size of the family unit able to work upstream. The reason the whole family migrates is that the entire family unit can work in the fields or in nearby packing and canning sheds. Regardless of the crop, growing seasons only last a short time. The family either maximizes the amount of money they can make per season, or they find themselves in serious financial trouble.

The whole family migrates to maximize the amount of money that can be made.

While states have various child labor laws, these are frequently ignored by both migrants and growers. Such laws are ignored because neither the growers nor the migrants want them enforced. For growers, child labor keeps the cost of harvesting low. For migrants, even the labor of a ten-year-old child doing piece work can make a significant contribution to the daily and weekly income of the family.

Child labor laws are ignored because neither the growers nor the migrants want them enforced.

Most families begin migrating when they have enough children aged ten and older so that both parents and at least two (and preferably more) children can work. Once the family size shrinks to only the parents and one child, they will drop out of the migrant cycle, unless they are attached to a larger, extended family unit. With so few laborers available, it is more economically feasible for them to work occasionally at their homebase and thus avoid the difficulties of migration.

The primary reason that individuals enter migrant farm work is to make more money than they could at home, or at least to make the same amount of money during a shorter length of time. The communities where migrants live, especially the homebase areas, have been economically hit hard, as with the rest of agricultural America. This contributes to the economic decline of businesses in those areas far beyond the farm. Migrant farm work provides individuals economic leverage that other temporary workers often lack. For a family of six, making $10,000 in four months, rather than working on and off for 12 months at their homebase, allows them considerable economic clout and flexibility.

A day's loss of pay for any member of the family is an economic disaster.

For example, migrants can use the money they earned from one season's farm work to buy a piece of land, or at least make a down payment. Then they can manage to get by, barely subsisting until the next season. With the money from that season, they can put in a concrete slab and basic plumbing, and subsist until the next season. After several successful seasons the family can own property, have a home, and/or buy a pickup truck.

The premium placed on not losing a day's pay means that adults will frequently not seek outside help for anything less than absolute collapse or crisis.

This only works when all family members above the age of ten or twelve contribute their labor to the general pool. This also means that a day's loss of pay for any member of the family, but especially for the adults whose piece work volume is much greater than a child's, is an economic disaster. This is one reason that many adults ignore medical complaints until they reach crisis proportions and the labor loss cannot be avoided. In contrast, however, most children's illnesses, especially if considered serious, will be taken care of very quickly, even if it means loss of pay for one of the adults taking a child to a clinic.

The premium migrants place on not losing a day's labor is one reason why many migrant health centers remain open in the evening, when migrants are not working. The premium placed on not losing a day's pay also means that adults will frequently not seek outside help for anything less than absolute collapse or crisis. Even the reduced work that someone can do when they are sick, or sore, or exhausted, can make a significant difference in the day's pay.

Health insurance is neither affordable nor available to the vast majority of farmworkers.

The economic leverage of migration is a relative gain, not an absolute one. The total earning power of migrant and seasonal farmworkers is quite limited.

Ten years ago, apple harvesters in the Northwest earned about $14.00 for picking a ton of apples. In the fall of 1985, they earned between $15.00 and $16.00 per ton. Putting this in medical purchasing equivalents, in 1975 picking a ton of apples paid for a routine office visit. Today, it costs at least two tons of labor for that visit. In 1975, a chest X-ray cost a harvester the equivalent of two and one-half tons of picking. Today it costs nearly five tons.

In an entire apple harvest season, assuming the family did not eat or live in housing they paid for, or buy anything whatsoever for the whole year, it would still be impossible for a migrant family to pick enough apples to pay for any really serious illness or major surgery for any member of the family.

In addition, financial incentives for Hispanic American farmworkers are constantly being eroded. On one hand, living expenses such as fuel, vehicle, housing and clothing costs have gone up making migrant labor difficult. On the other hand, the worsening financial situation in Mexico has greatly increased the incentives for Mexican Nationals to cross the border and work in the fields. This situation can create a number of serious health conditions for the United States that do not occur when farm labor is done by U.S. citizens. These include infectious diseases from low immunization rates, the introduction of tropical and other exotic diseases into the U.S., and the reintroduction of diseases, such as polio, that had been reduced or eradicated in the U.S.

The worsening financial situation in Mexico has greatly increased the incentives for Mexican Nationals to cross the border and work in the fields.

Living Conditions

Migrant farmworkers experience Third World health conditions due to a lack of the sanitation and environmental improvements widely available to the rest of the United States.

Knowledge of migrant living conditions is important because there are constraints placed on the health care system by living conditions that migrants encounter. Environmental conditions may dictate the types of prescriptions that can be realistically used. If a patient does not have access to a refrigerator, drugs that need refrigeration are impractical to prescribe. Follow-up visits may have to be scheduled to accommodate the picking season. If not, then the patient may be gone before the follow-up appointment time arrives. Special attention is needed to help migrants find ways of protecting their health when they have no hot water to wash with, no toilets at home or in the field, and no screens on the windows. These conditions can make hygiene and health education especially challenging.

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Many of the major advances in the health status of modern society have come from changes in sanitation and environmental improvements. Better nutrition and hygiene are two major reasons for the decrease in the incidences of many major health problems in developed nations. Far too many migrants encounter poor public health conditions as found in developing nations. Migrant farmworkers experience Third World health conditions due to a lack of the sanitation and environmental improvements widely available to the rest of the United States. A major part of the health education needs of migrants are directly parallel to the health education needs found in Third World or developing nations.

There is a considerable gap between the working and living conditions experienced by migrants and those experienced by the majority of other workers in the U. S.

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A national survey on migrant health (Trotter, 1984) identified the basic sanitary and environmental resources available to most U. S. citizens which were absent in migrant housing.

Typical Housing Resource	Migrant Households Lacking Resource (%)
Adult recreational facilities	63.0%
Toilet in same dwelling	41.5
Phone in dwelling	35.9
Screens on all doors and windows	32.1
Transportation for emergency	31.2
Windows in rooms where people lived or slept	21.3
Hot running water	19.4
Safe play area for children	18.9
Television	17.8
Bathtub or shower	14.7
Flush toilet	11.2
Radio	8.3
Working refrigerator	5.5
Cold running water	4.5
Gas or electric burners	3.7
Electricity	3.7

Migrants have to cope with generally poor living conditions both at their homebase and at upstream migrant camps. For many, but not all migrants, homebase environmental health conditions are considerably better than upstream conditions. For some migrants, upstream conditions may actually, because of stricter state laws, be better than those found at homebases.

Migrants have to cope with generally poor living conditions both at their homebases and at upstream migrant camps.

Substandard housing conditions, which migrants are exposed to, contribute significantly to their negative health status.

Each state and each region within the migrant streams have different laws and different priority levels for enforcing the laws dealing with farmworker housing. As an overall assessment, the substandard housing conditions, which migrants are all too often exposed to, contribute significantly to their negative health status. These conditions increase the number of upper respiratory infections, the number of diseases that are related to lack of sanitary facilities and potable water, and the diseases which are related to stress from heat and cold.

Work Environment-Work Hazards

The frequent lack of shade, toilets, hand-washing or drinking water, and transportation at the work site explain high incidences of certain medical conditions seen in migrant health centers.

In addition to having to cope with less than ideal environmental conditions where they live, migrant families are also exposed to very unhealthy sanitary conditions and to very high accident risk situations in their work environment.

The following illustrates the poor conditions found nationally at migrant labor work sites (Trotter, 1984). It should be noted that in specific areas or states, conditions may be significantly worse.

Field Work Site Condition	Migrants Indicating a Lack of Condition (%)
Drinking water in field	14.3%
Hand washing water in field	38.1
Toilet in field	38.5
Shade available at work site	46.2
Transportation for emergencies available at work site	15.1

The lack of such work site conditions help to explain the high incidence of certain types of medical conditions seen in migrant health centers. The lack of shade and drinking water directly contribute to serious cases of heat prostration and exhaustion. The lack of toilet facilities contribute to the incidence of diseases related to poor sanitary conditions. The lack of water for hand-washing contributes to sanitary problems, as well as to problems from exposure to pesticides by people working in sprayed fields. The lack of transportation can contribute to serious delays in the time it takes for people to receive care for emergency conditions.

Farm labor is one of the top three occupations with the highest rates of occupationally related injuries and illnesses.

Farm labor is one of the top three occupations with the highest rates of occupationally related injuries and illnesses. Occupational hazards for migrant farmworkers include trauma from farm equipment. Most migrants have had at least one major accident. Many also suffer from chronic back pain and/or eye problems, even including incipient blindness due to exposure damage to the cornea. Back injuries are often unrealistically minimized by medical professionals, with the laborers being told they can work as long as they avoid stooping and heavy lifting. Without lifting and stooping, there is little left for the migrant farm laborer.

Children are particularly at risk in farm work environments.

Children are particularly at risk in farm work environments. When they work with their parents in the fields, they are exposed to the same occupational hazards that adults face. At the same time, however, children have less experience or skill in avoiding problems than that of adults. If younger children are left to play alone while the adults and older children work, they can be injured or harmed by accidents, pesticide exposure, or other environmental hazards.

Pesticides and Migrant Health

There is growing evidence that the problems with pesticide exposure are similar to the iceberg phenomenon: only the "tip of the iceberg" or most obvious cases are noticed, while the majority of cases are "hidden beneath the water" and go unreported or unrecognized.

Pesticide exposure is a significant hazard for migrant and seasonal farmworkers. There is growing evidence that the majority of pesticide exposure goes unreported.

The individuals most at risk of being poisoned are the pesticide applicators, which in some cases may be a farmworker. Newer pesticides are extremely toxic; before they are diluted for application, no more than two or three drops on the skin can be fatal. The risk of accidental exposure from being sprayed, from drift from a nearby field, or from reentry into fields too soon after they have been sprayed, then shifts to farmworkers and their children. Even low level exposure can cause symptoms that range from rashes, nausea, vomiting, blurred vision, to extreme lethargy and unconsciousness.

Given the general nature of symptoms of pesticide exposure, many cases are either incorrectly diagnosed or not identified. A clinically obvious (epidemiologically evident) case of poisoning will be identified and managed in an expert fashion. However, when the case is subacute and there is no obvious recent exposure, the case may well be missed when it is seen in the same examining room with a multitude of patients with symptoms such as headaches, dizziness, and abdominal discomfort.

Providers must increase their level of suspicion of poisoning when confronted with classic symptoms, even in subacute cases.

Due to these problems, two levels of actions are needed. First, providers must increase their level of suspicion of poisoning when confronted with classic symptoms, even in subacute cases. Too often these cases are dismissed without serious exploration as anxiety, depression or somatization syndrome. With increased suspicion and screening, the second action needed is to institute preventative measures and pesticide education for farmworkers.

Field Sanitation

As might be concluded, migrants have to put up with working conditions that would be unacceptable to most U. S. workers. Although passage of a recent national standard requires field sanitation facilities few facilities (such as portable toilets), are found in field work sites. Few states have the staff needed to enforce these regulations. This means that farmworkers (men, women, and children) must either go to the bathroom in the fields or must wait until a 12- or 14-hour hard labor day has ended. With row crops there is often not even a clump of trees nearby to provide privacy. Women and girls will often limit the amount they drink, rather than expose themselves in this way. This leads to increased urinary tract infections and to a higher risk of heat prostration. These conditions are neither reasonable for migrants nor for end consumers of the crop, who may be exposed to feces-vectored illnesses.

Farmworkers must either go to the bathroom in the fields or must wait until a 12- or 14-hour hard labor day has ended.

Not only are toilets not available, too often running water to drink or wash with is nonexistent. During lunch breaks pesticides or disease organisms may be transferred to the mouth. This contributes to the high incidence of Shigellosis, salmonella infestation, parasitic diseases, hepatitis, and chemical dermatitis which plague migrants.

Not only are toilets not available, too often running water to drink or wash with is nonexistent.

Lack of Labor Benefits

Most workers in the United States enjoy some level of employment-related benefits. Many of these benefits have been systematically denied to migrant and seasonal farmworkers, contributing to their poor health status. An example of this, as shown in policies implemented by both federal and state

Benefits have been systematically denied to migrant and seasonal farmworkers.

governmental agencies, is the exclusion of farmworkers from the guidelines for workers attempting to organize (National Labor Relations Board Guidelines). Farmworkers have been selectively excluded from Occupational Safety and Health Administration regulations. The OSHA standard requiring agricultural employees to provide field sanitation facilities for farmworkers was issued only after 14 years of litigation.

A farmworker is usually not eligible for benefits for an injury resulting in the same type of disability for which another worker in a different type of employment will receive benefits.

In some states workers handling dangerous chemicals must go through a specific education program to minimize health hazards from toxins, with the exception of farmworkers. Worker's compensation for farmworkers varies significantly from state to state in terms of reimbursement of injuries and disabilities occurring at the work site. A farmworker is usually not eligible for benefits for an injury resulting in the same type of disability for which another worker in a different type of employment will receive benefits. Obviously these inequities lead to health problems which directly effect migrant health centers as well as the migrants themselves.

Home Health Care/Folk Medicines

Therapies of the home health care system are highly beneficial to the comfort of the patient.

When they migrate, many farmworkers carry with them some home remedies, first-aid kits, and over-the-counter drugs to take care of minor problems. Many OTC drugs should be considered folk medicines, since they are often used in ways for which they were not intended. The health care professional should be aware that most of these will be used prior to the person seeking professional help.

The use of herbal teas is widespread in Mexican American households.

For example, the use of herbal teas is so widespread in Mexican American households that no one will think it worth mentioning that a child or adult is being given those teas. Many of these teas are biochemically active; therefore, they may cause unexpected drug interactions, or interfere with prescription medicine.

A Hispanic woman had a heart condition for which her physician prescribed digitalis. After a couple of weeks at home she was hospitalized for a digitalis overdose, and her dosage was lowered. After her third overdose it was discovered that her maid, who was from Mexico, had faithfully given her a medicinal tea three times a day to help her get over her heart condition. The medicinal tea was foxglove tea, a natural source for digitalis.

If a drug interaction problem is present and there is no obvious connection with other prescription medicines, it is a good idea to investigate for possible interference from use of a folk remedy. These cases are rare. For the most part, the teas and other therapies of the home health care system are highly beneficial to the comfort of the patient. The health care provider can gain substantial rapport by being open to the use of home remedies, where they are, at worst, a placebo.

If a drug interaction problem is present, it is a good idea to investigate for possible interference from use of a folk remedy.

As mentioned earlier, migrants' beliefs include those about various folk illnesses that do not at a provider's first acquaintance, match with modern medical diagnoses. It is inevitable that the cross-cultural health care provider will sooner or later encounter both folk-labeled illnesses and the effects of home remedies. The most appropriate and productive reaction is to demonstrate a neutral, if not compassionate, attitude toward these practices. This is an area where criticism of beliefs rapidly leads to deterioration of confidence in the health care provider.

It is inevitable that the cross-cultural health care provider will sooner or later encounter both folk-labeled illnesses and home remedies.

III. Overview of Migrant Health

Migrant and seasonal farmworkers and their dependents experience more frequent and more severe health problems than the general United States population. Only a limited number of scientific studies have been made on the health status of migrant and seasonal farmworkers. Research on migrant health has been largely neglected by the scientific community. This is especially true of clinically-based studies and of traditionally-designed studies on the incidence and prevalence of diseases in the migrant population. Those studies on migrant health which have been conducted have relied primarily on self-reporting of problems, retrospective recall of illnesses, or have focused primarily on the social barriers that hinder the delivery of health care to migrants.

Migrant and seasonal farmworkers and their dependents experience more frequent and more severe health problems than the general United States population.

The most comprehensive report on migrant health status comes from a project conducted in Tulare County, California (Mines and Kearney, 1982). The project combined ethnographic research with a well-constructed survey of more than 1000 migrant families. This created a data base exhibiting both intimate detail and a sound methodological estimate of the distribution of the problems discovered in the population.

Tulare County, California, report on migrant health status.

The Tulare project data supports the contention that migrants will seek health care services, if those services are made available to them. Farmworkers actively sought conventional care at a rate of 4.4 visits per year per person. In fact, the overwhelmingly Mexican migrant farmworker population of Tulare County actually takes its children of less than 15 years of age to doctors at rates above the national average. Individuals over 65 years of age also seek services at rates above the national average, while groups between these two age groups seek care at rates below the national average.

The Tulare project data supports the contention that migrants will seek health care services, if those services are made available to them.

Both minor and serious health conditions are covered in the report, as well as maternal and child health, environmental conditions, and migrants' attitudes towards medical services. The most common minor conditions reported were bleeding gums, backache, nervousness, headaches, and strong anger. The most common serious conditions reported were anemia, high blood

pressure, diabetes, tuberculosis, heart attack, lazy eye, venereal diseases, paralysis, cancer, and dental problems.

The most common serious conditions reported were anemia, high blood pressure, diabetes, tuberculosis, heart attack, lazy eye, venereal diseases, paralysis, cancer,and dental problems.

The Tulare County report provides age-specific data on health and other conditions:

29 percent of migrants suffered from some form of mild psychological distress,

28.5 percent have had injuries due to accidents,

24 percent of farmworker women had suffered miscarriages (and 6.9 percent have had still births),

19.6 percent reported dental problems,

9.4 percent reported orthopedic/musculoskeletal problems,

5.1 percent had respiratory problems, and

1.4 percent had serious mental problems.

Education should be presented in culturally appropriate ways, and focus on disease causation, prevention, and treatment, especially in the areas of perinatal care, sanitation, and nutrition.

The recommendation section of the Tulare report clearly distinguishes between the responsibilities relegated to health and education professionals and those areas in which migrants can and must take responsibility for their own care. The authors state, "there is great need for education to migrants about basic health principles", (Mines and Kearney, 1982:122). Education should be presented in culturally appropriate ways, and focus on disease causation, prevention, and treatment, especially in the areas of perinatal care, sanitation, and nutrition. They conclude that this education is needed "to give farmworkers the knowledge to make simple but effective changes in living patterns that have direct effects on health" (Mines and Kearney, 1982:123).

The second-most comprehensive report on migrant health status is contained in a report on the health status of migrants in Wisconsin (Slesinger, 1979). It, too, used a combined ethnographic and survey methodology to gather the data reported. The report contains a description of the migrant population in Wisconsin and a report on their health status and resource utilization patterns. The ten most commonly mentioned health conditions are headaches, eye trouble, backache, tooth and gum problems, nervousness, irritability, insomnia, depression, and stomach pains.

Wisconsin report on the health status of migrants.

The ten most commonly mentioned health conditions are headaches, eye trouble, backache, tooth and gum problems, nervousness, irritability, insomnia, depression, and stomach pains.

The Wisconsin report also presents information on chronic illnesses. The most commonly mentioned chronic conditions for Wisconsin migrants are: blindness/eye troubles, chronic nervousness (medicated), back or spine trouble, missing fingers and toes, arthritis, drinking problems, sinus problems, kidney problems, asthma, deafness, allergies, heart problems, and permanent stiffness or deformity.

Other questions determined that migrant attitudes toward utilization of health services in Wisconsin were virtually identical with those reported in the Tulare County survey. The Wisconsin report provided a ranking of the most common barriers migrants experience in seeking health care. These were:

1 - The time it takes to get an appointment
2 - Distance to the facility
3 - Language barriers
4 - The times at which the facilities are open
5 - The cost of services
6 - Loss of income from using services
7 - Feeling uncomfortable with the doctor
8 - Lack of knowledge of who to go to
9 - A fear of what the doctor might find

The migrants indicated virtually no interest in having access to three types of services: alcoholism services, family planning, and

mental health services. Other notable findings were that one-third of migrants had never visited a dentist, and one-tenth of the children had never been immunized. In addition, one-fifth of migrants were suffering from some type of psychological distress, such as insomnia, irritability, nervousness, and "low spirits". Finally, questions on environmental conditions determined that over 50 percent of migrants needed flush toilets, better sewage, and better garbage disposal conditions.

Other reports on migrant farmworker health status.

Several other reports are worth mentioning. Two reports indicate that the nutritional status of migrant farmworker children demands attention and education (Chase, et al., 1971; Larson, et al., 1974). Nutritional deficiencies common in migrant children include anemia, and vitamins C and A deficiencies. Three reports deal with general health status of migrants (Education Commission of the States, 1979; Speilberg-Benitez, 1983; Barger and Reza, 1984). The conclusions parallel those of the two broader reports described above: migrants have more health problems than do equivalent nonmigrant workers.

It is not simply the farmworkers' education status which prevents them from moving into a permanent employment setting, but also their health status.

One author (Speilberg-Benitez, 1983) demonstrates that migrants' health status may also perpetually keep them in migrant farmwork. Based on a comparison with blue collar workers in a major homebase area for migrants, his data indicate that it is not simply the farmworkers' education status which prevents them from moving into a permanent employment setting, but also their health status. He states that improvement of the health status of farmworkers facilitates their movement out of agricultural wage labor (Speilberg-Benitez, 1983).

Common Health Problems

The overall medical and dental problems encountered in migrant health centers are not dramatic, except on a quantitative basis: there seems to be more of everything.

The overall medical and dental problems encountered in migrant health centers are not dramatic, except on a quantitative basis. There seems to be more of everything, and common conditions have been allowed to progress to very serious stages. The majority of migrants' health problems are identical to the health problems

encountered in any poor population in the United States. These are the illnesses which are caused by poor nutrition, lack of resources to seek care early in the disease process, accidents and exposure from hard manual labor, and infectious diseases from overcrowding and poor sanitation.

1. Minor Health Problems

Migrants experience a large number of minor ailments. They also identify and treat some conditions as ailments which are actually underlying symptoms of other illnesses and which would be taken as signs of more serious health problems if they were clearly presented to health professionals. The potential lack of awareness that a condition, such as diarrhea or fever, might indicate a more serious underlying problem will sometimes cause delays in seeking professional medical attention.

Migrants identify and treat some conditions as ailments which are actually underlying symptoms of other illnesses.

An earache is a minor condition if treated properly, but it can lead to deafness if not treated. Deafness is in no way a minor problem, and is one of the frequently mentioned major health problems in the migrant population. The results of this section should not only be interpreted in terms of the high level of minor problems which migrants experience because of their working and environmental conditions, but should also be interpreted from the perspective of how these minor problems can be overcome to prevent major health problems from occurring as a consequence.

An earache is a minor condition if treated properly, but it can lead to deafness if not treated.

In support of the above information, an original study was conducted by interviewing representatives of migrant families in migrant health centers and asking them to list the illnesses encountered in their family unit during the past 12 months (Trotter, 1984). These were then divided into minor and major illnesses.

The following data represent a ranking of the minor illnesses by the percentage of families which report at least one member of the family having had the illness or symptom during the past 12 months (Trotter, 1984). These percentages reflect data at a national level; incidences may be significantly higher in specific states or areas.

Illness/Symptom	Migrant families reporting illness (%)	Illness/Symptom	(%)
1. Colds	65.4%	20. Swollen joints	20.6%
2. Headaches	63.0	21. Indigestion	20.4
3. Flu	57.0	22. Sores	20.2
4. Toothaches	47.2	23. Constipation	18.9
5. Ear problems	43.5	24. Vomiting	18.1
6. Sore throats	42.1	25. Blurred vision	17.8
7. Backaches	39.8	26. Menstrual problems	16.8
8. Eye problems	35.2	27. Gum problems	15.7
9. Coughing	34.0	28. Burns	15.7
10. Allergies	31.4	29. Unusual weakness	15.4
11. Fever	31.3	30. Nausea	15.2
12. Stomachaches	30.8	31. Shortness of breath	14.8
13. Cuts	29.7	32. Chest pains	14.2
14. Diarrhea	28.6	33. Lack of appetite	14.2
15. Rashes	27.9	34. Bladder problems	10.4
16. Nervousness	25.9	35. Congestion	10.3
17. Colic	25.5	36. Boils	9.4
18. Sinus problems	24.3	37. Large weight loss	6.3
19. Insomnia	22.9		

Preventative health care and health care screening are being done, but the migrant lifestyle causes each of these efforts to be both too successful and not successful enough. There is probably no other population in the United States that has had simultaneously high incidences of both over-immunization and under-immunization of children. Many pediatric migrant patients have been immunized four or five times in the same season, due to the problems of continuity of care, while others have been missed completely for the same reason. The primary list of minor health problems most frequently encountered includes rashes, strains, sprains, upper respiratory infections, otitis media, abdominal discomfort, diarrhea, urinary tract infections, anemia, lacerations, headaches, and dizziness.

The migrant lifestyle causes efforts to be both too successful and not successful enough. Many pediatric migrant patients have been immunized four or five times in the same season, while others have been missed completely.

2. Major Health Problems

All of the health care problems found in the general population are found in migrant groups. Some, however, occur more frequently. These include diabetes, cardiovascular disease, and asthma.

Dental problems abound in migrant farmworker populations, yet dental care takes very low priority in the help-seeking behavior of migrants. Routine examinations of both children and adults reveal catastrophic dental sequealae. Bottle mouth caries is a relatively common problem, and gingivitis is rampant among adults.

Routine examinations of both children and adults reveal catastrophic dental sequealae.

Prenatal care for migrant mothers is difficult, and many of the pregnancies are high risk. There are high levels of pregnancies in both very young and much older women. The absence of prenatal care, especially early in the pregnancy, is common, as are multigravid females. These conditions lead to a high incidence of premature births, preeclampsia, and other complications.

The absence of prenatal care early in pregnancy is common.

The major illnesses listed below, represent both acute and chronic conditions serious enough to warrant medical attention on either a temporary or permanent basis (Trotter, 1984).

	Major illness	Migrant families reporting illness (%)
1	Eye problems	35.2%
2.	Depression	23.1
3.	Anemia	21.7
4.	Arthritis	18.9
5.	High blood pressure	16.8
6.	Still births	16.2
7.	Kidney problems	14.8
8.	Obesity	14.3
9.	Problems during pregnancy	13.4
10.	Asthma	12.5
11.	Intestinal parasites	11.3
12.	Deafness	11.2
13.	Heart problems	11.2
14.	Ulcers	9.4
15.	Sun stroke	9.4
16.	Diabetes	7.5
17.	Cancer	4.7
18.	Epilepsy	4.7
19.	Pesticide poisoning	4.3
20.	Liver damage	3.8
21.	Lazy eye	3.8
22.	TB	3.8
23.	Infertility	3.2
24.	Sickle cell anemia	2.9
25.	Alcoholism	1.9
26.	Polio	0.9

Tuberculosis deserves special mention. Active cases are consistently found, and routine PPD skin testing remains a very effective health screening policy for migrant health centers. There is a high proportion of reactors among migrants, consequently it is necessary to be selective in choosing which patients will follow conventional therapy.

Uncommon Health Problems

It is best to expect the unexpected in migrant populations. It is not unusual to encounter diseases that would be seen once in a lifetime.

It is best to expect the unexpected in migrant populations. While the majority of medical conditions seen in migrant health centers are common, it is not unusual to encounter diseases that would be seen once in a lifetime, if ever, in other groups of the U.S. population. Migrants not only live in Third World conditions, they are subjected to Third World diseases.

One of the basic rules in migrant health care delivery is that if a disease does not look quite right, or if it does not respond to conventional treatment, it should be investigated as a possible unconventional illness.

Diseases of yesteryear are commonly encountered, dominated by infectious diseases. Parasitic diseases and other gastrointestinal infections, including shistosomiasis, shigella, and salmonella, which are rare in the rest of the U.S. population, abound in the migrant population. Other exotic diseases such as amoebic liver disease, brucellosis, and echinococcal cyst disease are not uncommon. The majority of the cases of polio encountered in the United States in the past ten years have been found in the migrant farmworker population, with the majority coming from Texas migrants. One migrant health center in South Texas reported 10 cases of yellow fever in a single year. When a recent explosion in cases of Dengue fever occurred in Mexico, it was not uncommon for cases in migrants to be seen at migrant health centers. Nor is it uncommon for encephalitis, typhus, or even Hansen's disease to be seen in some migrant populations. Today's most feared disease, AIDS, is also present in migrant populations.

Certain groups pose special health problems and risks. Haitian farmworkers in the East Coast Stream comprise one such group. They often have active cases of diseases that have not been seen in the United States since widespread vaccination programs were begun. They may also present tropical diseases which have virtually never been encountered. Since Haitians are in contact with other migrants, those diseases can show up in both homebase and upstream areas that have never had a single Haitian resident in them. On the West Coast and in the Midwest, a similar condition occurs with some Southeast Asian workers. They sometimes bring with them diseases which were common in their homeland, but are very rare in the United States.

Barriers to Treatment

Migrant farmworkers experience many barriers to utilizing health care services.

Migrant farmworkers experience many barriers to utilizing health care services. Some of these barriers are institutional. Clinical facilities are too far away; they are not open at a time when migrants can come in; it takes too long to get an appointment, and the family may move before an office visit can be scheduled; or waiting times within the clinic are lengthy.

Some barriers to care are institutional; some are personal - such as loss of income.

Some of the barriers are of a personal nature. Migrants are reluctant to seek services; they don't want to bother the doctor over something that might be minor; they are afraid of what the doctor might find; or they have been the recipient of discriminatory practices. Some of the most important barriers are related to work and income. Migrants cannot always afford medical care, or cannot afford to lose pay for the time it takes them to go to a health care provider.

A sample of migrants were asked if they had not sought or had not received health care when they thought they needed it (Trotter, 1984). For each condition, the responses are shown below.

Problem/Barrier	Migrant responses by type of barrier (%)
Can't afford loss of pay	64.2%
Don't want to bother doctor	63.2
Facility not open at a time when migrants can go	60.0
Takes too long to get appointment	56.6
Can't afford health care	54.3
It is too far to facility	40.4
No child care available	34.6
No transportation available	29.8
Don't know of doctor	39.4
Don't believe in doctors	38.7
Person is never sick	35.2
Can't speak English	34.9
Afraid of what will be found	29.5
Take care of own health (don't need doctors)	19.4
Doctors are prejudiced	17.6
Friends/relatives had bad experience	15.9

To deliver health services in a migrant health center, unique characteristics must be taken into account in the organization of center staffing and the scheduling of the work flow.

Health Education Needs and Interest

Migrants have consistently shown interest in further health education, and especially that information which would give them more individual control over their own health.

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The following list is a ranking of health education interests by the percent of migrant households that indicated that they would like to know more about a specific health condition. It includes the illnesses for which at least 50 percent of the households surveyed indicated they would like to receive more information.

Health Condition	Migrant Families Requesting More Information (%)	Health Condition	(%)
Ear problems	64.6%	Stomachache	52.5%
High blood pressure	62.5	Shortness of breath	52.5
Sinus problems	62.1	Enlarged lymph nodes	52.4
Colic	61.9	Sore throat	52.4
Epilepsy	60.7	Pesticide poisoning	52.0
Swollen joints	60.7	Nausea	51.9
Allergies	59.7	Alcoholism	51.8
Nervousness	59.3	Polio	51.8
Blurred vision	59.0	TB	51.8
Diabetes	58.6	Boils	51.7
Asthma	58.3	Cancer	51.7
Insomnia	57.8	Anemia	51.6
Colds	57.6	Fever	50.9
Depression	57.6	Unusual weakness	50.9
Flu	57.6	Heart problems	50.8
Arthritis	57.4	Congestion	50.0
Deafness	57.4	Obesity	50.0
Gum problems	57.1	Lazy eye	50.0
Kidney problems	56.9		
Eye problems	56.1		
Toothache	56.1		
Rashes	55.9		
Chest pains	55.7		
Bladder problems	55.2		
Sickle cell anemia	54.7		
Liver damage	54.4		
Sores	54.4		
Vomiting	54.2		
Large weight loss	54.0		
Ulcers	53.4		
Headaches	52.9		
Sunstroke	52.9		
Intestinal parasites	52.6		
Indigestion	52.5		

Continuity of Care

Continuity of care is one of the most difficult issues in quality of care for migrant farmworkers. The mobility of migrants, even when many return to the same area year after year, makes continuity of care difficult. Geographic relocation may occur several times during the course of a year. At the same time, it is not unusual for some states to observe that, in a given year, as many as half of the migrants are there for the first time. Just as a course of treatment is started, migrants may move on to a new location following the cycle of the crops, or they may move back to their homebase because the season has ended and there is no more work.

Continuity of care is one of the most difficult issues in the health care of migrant farmworkers.

Just as a course of treatment is started, migrants may move on to a new location, or they may move back to their homebase because there is no more work.

It is difficult to enable communication between migrant health centers and with other providers for each migrant patient's health status or needs. Centers have standardized record systems, but the systems vary enough to produce some confusion. Most centers provide migrant families with copies of their own charts to take along with them or with small health record cards. Many migrants keep these charts or cards for years; some are lost immediately. Some centers send automatic letters to the next most probable location, although many times a migrant may never get there because something intervened between intention and execution.

The disruption in chronic disease management is common, based on the problems built into the nature of the migration cycle. A provider may find a patient taking twice the proper amount of prescribed medicine because one was listed by the brand name and the other by generic name. The patient thinks it is two different medicines, one diagnosed and prescribed at a homebase center, and the other at an upstream center. This may even occur with two upstream centers. Between centers, neither knows that the other is involved.

The disruption in chronic disease management is common.

It is a good idea for providers to ask to see all of the medications that a patient with chronic problems is taking. This catches some of the duplication, and may also identify home remedies used or medications obtained in Mexico.

It is a good idea for providers to ask to see all of the medications that a patient with chronic problems is taking.

There is no clear solution to the problems of interrupted continuity of care for migrants. It is extremely important, therefore, that health care professionals understand the elements underlying the problems and take as many defensive measures as possible so that disrupted or duplicated services can be avoided to the maximum extent possible.

Quality of Care

Migrant health centers, as a whole, deliver high quality care. This is often accomplished without the latest equipment, with very moderate budgets, and in spite of cultural and environmental barriers listed previously.

Even without the latest equipment, modest budgets and cultural and environmental barriers, migrant health centers deliver high quality care.

Quality of care is a must, but at the same time there is no financial room to practice the same level of defensive medicine as that possible in other health care settings. If one test is most likely to confirm a diagnosis, only that test and not a half dozen others is run.

Quality of care in migrant health centers is dependent upon maximizing the skillful use of available resources. Working from within the system, providers with creative minds use the constraints on their center to produce innovative means for overcoming barriers to good care.

Quality of care in migrant health centers is dependent upon maximizing the skillful use of available resources.

For those who want to practice medicine, dentistry or nursing where their efforts will make a major impact, rather than a minor ripple, it would be difficult to find a more interesting, challenging, or rewarding arena than that found in migrant health centers.

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