New Roads for Migrant Health -

CHARGE TO THE MID-CONTINENT CONFERENCE

Setting

What is this Mid-Continent? Bounded by Mexico on the South, Canada on the North, and mountain chains on the East and the West, it is one of the largest and most fertile agricultural land masses in the world. Much of it is sparsely settled. Its major population centers are scattered and few in relation to its great spaces. Health services are concentrated in these major centers.

Within the Mid-Continent many thousands of people move each year - men, women and children, - travelling by truck, car, trailer and bus. They start north as soon as the first hint of spring is in the air. A crop guide published by the Department of Labor describes the work they are expected to do:

> Beans - The picker must have the judgment to pick the mature beans and leave the younger beans for later picking. Crawling, crouching, stooping, walking and kneeling are the physical demands.
>
> Tomatoes - The picker...works in a stooping position.
>
> Potatoes - The potato digger...must exercise care not to leave potatoes in the rows. Works in a kneeling position and progresses along the rows

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Presented by Helen L. Johnston, Coordinator for Migrant and Rural Health, Mid-Continent Conference on Migrant Health, Albuquerque, New Mexico, April 8 1969

...A good worker should pick from 75 to 150 field crates (60 pounds each) per day.

More than 200,000 migrants call the Mid-Continent "home." Three-fourths are from south Texas. They fan out from the Rio Grande Valley to hundreds of counties in 40 States. They go to the East Coast and the West Coast as well as through the Mid-Continent.

Other Mid-Continent States also contribute workers and families to the migratory streams. New Mexico with 24,000, Michigan with 14,000, and Missouri with 7,000 follow Texas in total numbers.

The 14,000 Michigan home-based migrants illustrate the growing tendency of some workers to settle in the north, although continuing to migrate when the season starts. Their range of movement usually becomes shorter. Eventually most drop out of migratory farm work completely and are replaced by more recent arrivals.

All Mid-Continent States except South Dakota use at least a few migrants at the peak of the crop season. (South Dakota supplies about 2,000 workers to other States.) As labor-users, Michigan and Texas top the list with numbers of workers and dependents totalling 84,000 and 96,000, respectively. In addition, more than 10,000 workers and dependents from other places are to be found annually in the camps and fields of Colorado, Illinois, Indiana, Ohio, Oklahoma, and Wisconsin.

The large majority of migrant workers become "surplus" when the season ends and they return to their homes. On their annual work itinerary they may earn just enough to maintain themselves while they are away. As one

when we left and broke when we came home."

The per capita income of one south Texas county with many home-based migrants is $827. For the United States as a whole, the median income of households headed by migratory workers is slightly more than $2,500. The households average four members, two under 14 years.

The majority of migrants in the Mid-Continent are of Spanish-speaking background. Mingled with them are Negroes from Mississippi, Missouri, Florida and other southern States; Indians from reservations of the Southwest and the Dakotas; and a few "Anglos."

An underlying problem for many migrant adults is their lack of knowledge or skill to obtain entree into other occupations. Another underlying problem is the fact that even if other jobs were available, and the people had the knowledge and the skill to qualify, there would still be a need for migratory workers in agriculture. Machines have shortened the season of labor demand in some crops and almost eliminated the need in others. Still the Mid-Continent States continue to require many thousands of stooping, kneeling, stretching, reaching workers to plant, cultivate or harvest their tomatoes, beans, cherries, strawberries, peaches, plums, apples, melons, and sugar beets.

In a very real sense the Mid-Continent States cannot be viewed alone when looking at migrants and their problems. The Mexican-Americans from the Rio Grande Valley furnish much of the labor for both coasts as well as for the Mid-Continent. Florida on the other hand, is an important source of labor for

so-called major migratory streams. For thousands of individuals and families, the "streams" are a fiction.

Nor do we in the migrant health field now stand alone as we view the Mid-Continent migrants, and all the ramifications of their health problems as they move within and beyond Mid-Continent boundaries. We are surrounded by other health and health-related programs of the Public Health Service, Social Rehabilitation Service, Department of Agriculture, Office of Economic Opportunity, Office of Education, and other agencies.

We find that the staff of the Department of Labor and the Office of Economic Opportunity feel the same sense of urgency we do to inter-relate services along major migration routes. Only in this way can people have continuity of services even though they move.

What has been done

In this Mid-Continent setting, our purpose today is to review the Migrant Health Program--to look at what has been done, what needs to be done, and what our guidelines for the future should be. Our chief tool at present continues to be the Migrant Health Act. This Act authorizes the Public Health Service to make grants to either public or private nonprofit organizations to pay part of the cost of operating family health service clinics and taking other action to improve migrants' health services or conditions.

In providing this authority, the Congress recognized that local community planning and organization to make health care accessible to migrants when and where it is needed is highly complicated, and requires

and other health workers. The movement of the people from one locality or State to another, their geographic and social isolation from communities, and their poverty are among the factors that make them difficult to serve.

In the 18 Mid-Continent States which send out migrants or have them coming in to work, 435 counties have 100 or more migrants at the peak of a normal crop season. Sixty-four projects now offer personal health care in 169 counties--about two-fifths of the total number. These projects operate 80 family health service centers.

About one out of ten of the Mid-Continent migrants--nearly 36,000--received medical care from reporting projects during the most recent 12-month reporting period. Twelve thousand patients received dental care and a little more than 2,000 received hospital care. In addition, 61,000 field nursing visits and 82,000 sanitation inspections were made. These are preliminary, incomplete data, but they show substantial program activity.

The narrative reports from Mid-Continent projects also show accomplishment in new understanding of migrants and their circumstances, new relationships with a variety of groups and agencies, and rapidly expanding inter-area communication.

A newcomer to one project reported:

"At the Columbus...camp I was immediately impressed by the not-so-neat

corrugated steel walls and roofs and the numbered green wood doors. Inside, in the long center hall lined with one-room family apartments, the odors of cold, damp concrete and hot Mexican food prevailed. Outside, the divided bath-house, communal sink and clothes line dominated the yard completely devoid of grass.

"A family apartment consisted of one steel wall, three wooden walls, two doors, one window, one bed or bunk beds, a picnic table, a stack of packed suitcases, a peg for hanging clothes, and a plate for cooking. There is no central heating.

"We sold second-hand clothing because outright charity is offensive. At $1.50 per grocery box-full, one mother could pay only half down for her baby's clothes. ...

"The hardest aspect was the apathetic attitude. ..."

A project sponsored by a local Economic Opportunity Committee furnishes examples of new relationships. The project arranged to use a Seventh Day Adventist Church School as a clinic site. Referrals from the clinic were followed by the local public health nurses. Six physicians from the nearby University volunteered their services. Two of the physicians' wives were nurses and they, too, volunteered. Emergency dental patients were referred to a nearby project with a full-time dentist. The county welfare department assisted with hospital bills. The employment office told migrants about the clinic when they registered. The local priest announced the availability of the clinic at his Spanish masses. Other less formal relationships were established on an ad hoc basis to meet special program needs and special needs

migrants came to the Texas State Board of Health during the last project year, compared to 107 in the previous year. This is just one measure of the rapidly expanding communication between projects to provide continuity of care even for people who travel great distances. As the result of such communication, a woman operated on for a malignancy in one State received x-ray therapy in the next. A child evaluated for cleft palate repair in one locality was treated in another, and project staff members served as "stand-ins" for his parents during his hospitalization while the parents worked temporarily in a third State.

Boundary lines between neighboring counties and States are also being obliterated as project staff members work across them. Thus the Mason City, Iowa, and the Minnesota projects cooperate in serving a shared migrant population. In Ohio, Lucas County family clinics serve migrants from adjoining counties. And there are many other examples.

What the people say

A group of physicians serving local projects met together in California a year ago to talk about what they were doing. To the facetious question: Would you want your Mother to go to a migrant family clinic? their answer was: "No, my mother should not go..., but, it's all right for my mother-in-law."

planning and operation--said: "What is migrant care? ... Without hesitation I can say it is stop-gap care. It is superficial care, it is fragmented care; it is on-the-run, band-aid care. ... Migrant care varies from place to place, in style, procedure, routine, quality, availability and extent. For the patient it lacks consistency and familiarity. ... It is a second-rate medical care system which we claim is justified because it is better than nothing. ..." However, in reviewing what the migrant thought as reflected by the reports of local aides, this physician found the migrants looking not at the scientific but the human quality of service. "Not one mention in all the statements by the health aides was about health care; what really impressed the people was that someone cared."

A nurse speaking at the same meeting acknowledged the problem of the high-patient-to-doctor ratio but questioned whether the doctor let the nurse do many things that she could help with. "He doesn't have to see every single patient; he wouldn't have to see up to 60 and 70 patients at night if something were to be done about allowing prescreening by nurses, especially of patients who don't have acute illnesses. ..."

The growers also have a point of view. "No matter what we try to do for them, they undo it. We build houses for them, and they destroy them. We fix their screens, and they tear them within the same day. We try to get them to take care of things...where they live, everything from the house to their won belongings, and they don't seem to care. ...

"You could give them twice their salary and they'd still do what they do now... They'd drink itaway and waste it on a lot of junk they buy, silly trinkets and unnecessary luxuries if you ask me...and then they still wouldn't eat right if they could get as much money as anyone around here; and they wouldn't know how to save it and spend it sensibly the way you and I would...

"We won't be needing them anyway the way we used to; it's a matter of time when machines will take it all over, or most of it, and then we could use the educated ones; and just a few of them compared to what we have now could run a farm if they were intelligent enough...

"Meanwhile we're caught in the middle. We've got to worry about the market prices and weather and all the overhead we have and we have all the trouble of getting migrant labor and then keeping them steady and productive... It's easy to jump on us, but no one helps our vegetable prices the way they do some crops, and we can be wiped out in a season from a freeze or price drop, and when we need labor it's an emergency. Either those fields get harvested right away or they don't. An who's going to do it?"

And finally, and not least, the migrants have a point of view. "To me it is all right", says one migrant, that you have the migrant program to extend to the ones who need it. They are the ones to get the help. There are quite a few who are really poor. We live in a real poor commumity. Quite a few work... They only net $1.65 an hour. Some have up to 10 children in their house. They can't get the money from $1.65 an hour;

some work eight hours; some work six; that isn't enough wages for a person with a family to support--a family with food, clothing, and doctors' bills...

And another migrant says: "If people are sick enough, they go. If they are plenty sick." (Here the reference was to a community without evening family clinics.) "I would rather have the clinics," this woman continued. "You can get the shots for your children at night. In an emergency, you can go to the hospital. People like migrant people like to go to clinics because they are all together. They feel more comfortable there. ... I am for that mobile unit. Many of the workers have no way of going to these clinics. A mobile unit can be where the migrants are."

A crewleader suggests: "We need a telephone number to call. This would help everybody. It would help the migrant. It would save money for the government. The nurse would answer the call by a migrant for something that might be minor. It's possible there would be no need to see a doctor. The nurse could tell. ... We need a telephone number for each place we go. ... We need to get out information in Spanish--spot announcements early in the morning on the radio."

A patient of a family clinic reports: "I went to the migrant program to see if I could get my glasses fixed or whether I could change them. They are not very good for me to read... I am getting blinder and blinder every day. They have not got the money to replace this glass. I went just before I came here. They told me they did not have any money. Awhile back, I went to see if I could get my teeth. They did not have any money for teeth."

"We need dental care. ... Is dental care just to pull teeth?"

The importance of service schedules was emphasized by a mother of five children: "The nurse should go late in the afternoon to visit the camps. When we pick cherries, everyone leaves the camps. There is no one at the camps during the day."

In discussing different projects, a crewleader questioned those which served only a small proportion of local migrants. "I was wondering about not seeing more than 900 people. Many projects do not go any further than that. If all the people get a little benefit it would be better than if half of them got a lot and others got none."

A single male farmworker, never married, observed that project emphasis on family health services, in itself, creates a barrier to their use by the single male who feels himself "unwanted." He also observed that "Today workers may be picking potatoes in a place where they will become permanent residents. Up to now they can still use migrant clinics. We don't know what will happen next year. Maybe we should include what happens when mechanization comes... Clinics would be desirable even if people are residents."

On family planning services, migrants express generally favorable attitudes. One man comments: "We needed the kids to pick tomatoes. We needed the kids to pick walnuts. Now we have machines. 'Machismo' bit--we are changing. This is not important any more. The church is going to hit us a little hard but we can get around that. ... Understanding of 'machismo' can be used to make a man feel that he needs to be responsible

for every child that he brings into the world." And a woman comments: "The load has been on the women. If you explain it to the man, how hard working your wife is, he will realize that it is true that those days have passed; that the man thought the man was on top and the woman was on the bottom. Now we are meeting."

Contradictory to some degree was another woman's view: "Most men are very funny about those things. My sister has eleven children. Her husband is very proud."

There was agreement that not everyone can "sell" family planning to migrants. "It takes a special person... It cannot be a 'welcome wagon' type who says, 'See what we have for you!'"

On housing, migrants are often severely critical. "I think they ought to be a little more careful about what kinds of house they give the migrant workers. It is interesting that they protect more any kind of horse or cow than the migrant workers. ... They ought to see that they get a proper house--I don't say a city house--but where they will be protected from rain, where there is no wind coming in through the walls or underneath. Not any building that they used to use for animals and then they get the people in to harvest the crop and they just shove them in there."

On field sanitation facilities they are equally critical. "Privies in the fields? I have been a lot of places where they don't have any. The State takes care of sanitation? Sanitary facilities in the fields are lousy. Why could not an inspector go around to every field and grower? Hand grower a ticket--$50 first time; $100 second time; jail third time for no toilets,

become involved in planning and decision-making. "We thank you for the hand you have given," they say. "You helped us when we were like babies, crawling. Now we are learning. We, too, want to walk. Let us walk!"

What needs to be done

In spite of recent progress, in no project has the optimum of service been reached. The more effort the staff makes, the more problems are discovered, and the more frustration results as staff members try to overcome problems with limited resources. A project with a strong medical component may be weak in sanitation or in health education services. Few patients get the dental care they need. Few overcrowded family clinics permit a careful physical evaluation of each new patient, so that more than symptomatic treatment can be provided.

Corrections of housing defects are slow. Field sanitation facilities are still almost completely lacking.

The overworked field nurse or aide seldom has the time to make sure that her advice is understood and followed. Time seldom seems to be available for joint staff planning for health education, setting priorities, working out methods, and evaluating results. Everyone reports doing health education but very few report on what is done or on accomplishments. In nearly all projects, health education is left to chance rather than being a planned part of the service.

In all too few instances, too, are migrants and other essential groups involved in the planning and evaluation process. The apathy of migrants toward services reported by some projects may be a symptom of a variety of

and our services, then we can begin to make needed changes.

In the counties where no grant-assisted project exists, the migrant usually comes to attention only when an emergency makes his presence "news." The close of each season finds him quickly gone and as quickly, and thankfully, forgotten. The efforts of projects to refer patients are likely to break down in these non-project areas since no responsible person has been identified to receive referrals, to find the patient or for the patient to find, and to assist as necessary in getting follow-up care provided.

Guidelines for the future

The seriousness of the need cannot be questioned. Nor can the complexity and the fact that the need goes far beyond what health workers alone can accomplish. The Valley of Texas is the heart of the migrant situation for the Nation. More people migrate out of this area than from any other in the United States. Yet here there is little industry and little opportunity for work. This area is just one acute example of the pockets of rural poverty from which migratory farmworkers are recruited.

Acute needs for health care and health education characterize these poverty pockets. These needs demand our assistance in ways that will contribute as fully as possible to the efforts of other agencies with broad responsibilities for helping the people find a way out of their poverty. The manpower training and relocation programs that are directed toward migrants in these areas need the full support of migrant health projects to help assure the good health of the workers to be trained, and of the family members

Help of this kind is the most constructive we can provide. The alternative to these planned moves of migrants, prepared for in advance, is likely to be permanent stranding in a rural slum, or worse still -- an unplanned move to an urban slum where hopelessness and dependency will hasten the process of individual and family breakdown.

Somehow, as we work in such home-base areas we will need to do better than ever in weaving together the resources of migrant health with Comprehensive Health Planning, Title XIX, and other public and voluntary programs to help support care for the individual, and protection for his environment. Only in this way can a program be built to serve not only migrants but all their equally deprived neighbors of indefinite status who may change their minds overnight as to whether to migrate this year. And only a program directed to the total needy population of these areas will be truly efficient and effective in meeting the health needs of the migrant segment.

Health education for problem-solving is an essential component of health care for the individual, family and community in this setting. It must be much, much more than the "show and tell" type so often used with migrant workers and their families. It must be the kind that will help the people recognize and meet their own health problems in whatever environment they may live in the future - the kind that will help them walk alone when there is no longer a special project staff to encourage and backstop them.

needs elsewhere. As long as people move to meet demands of their labor in widely separated areas, we will need to continue to ask ourselves:

1. How can the flow of information about migrants' health requirements and the services they received be adapted to the way in which migrants themselves flow from one seasonal crop area to another? How can different areas plan and work cooperatively to avoid duplication or gaps in service?

2. The variety of situations migrants encounter as they move ranges from a fairly complete array of health services, well adapted to their situation and need, to almost complete lack of access to any health services. Confronted by this variety, what can they be taught about their own health care that will be practical for them to apply even though they may find themselves in a new camp and a new community in every season of the year? What methods of "learning by doing" will best help them understand how to identify and solve their own health problems?

3. How can health workers and others in migrant-impacted communities gain greater understanding of the barriers that stand between migrants and the health care they need, as an approach to removing barriers wherever migrants stay temporarily?

4. How can communities overcome the traditional planning of health services for the convenience of health workers rather than patients--especially patients such as migrants? As an example, how can communities overcome the traditional fragmentation of community health services with many specialized clinics and services at different times and places - a

5. How can the helping resources of communities from both public and voluntary agencies, including volunteer services, be coordinated for efficient, effective channeling to migrants?

6. How can the Migrant Health Program become more person-directed, looking at the migrant's needs as a total human being, and fitting health services into this framework?

7. How can the migrant become more involved in taking self-responsibility? in project planning and evaluation? in other action that recognizes him as an individual with a contribution of his own?

8. How can community, State and national commitment be built to the point that services will continue for as long as migrants' need endures?

It may be good at this point to remind ourselves that Federal, State and local committees and commissions have made reports and recommendations on the migrant labor situation for the last 60 years. Nearly 30 years ago a concerned Congressman said: "The American people are in process of deciding that there are some important domestic problems which cannot be postponed. ... Migration is on the list for immediate attention."

"Immediate attention" to some of the problems mentioned in this 30-year-old report has not yet arrived. The latest Congressional report on migratory farm labor, dated February 1969, quotes a migrant as saying "Life on the road is no life. You're near dead, moving here and there." Yet, the report comments, he still persists. And the report raises the question--will his Government--with respect to its actions in behalf of him and others like him--match his persistence?

This Conference is a point in a process--a process of planning, serving, and evaluating services in relation to human needs that started long before we met here. We hope that this Conference will be a significant point in the process and that its outcome will influence in a constructive way the future of the total effort in which we are engaged together.

U.S. Senate, Subcommittee on Migratory Labor, 91st. Congress, 1st session The Migratory Farm Labor Problem in the United States. Report Number 91-83 pursuant to S. Res. 22, Cong., 2d sess. February 19, 1969. 152 pp.

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Numerous unpublished reports of migrant health projects, chiefly in the Mid-Continent States; ublic Health Service files.

Unpublished reports of Migrant Health Project Review Committee meetings; Public Health Service files.