BHCDA SITE ASSESSMENT REPORT

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DATES OF VISIT	July 31, 1995 to August 4, 1995
PARTICIPANTS:	Edward Capparelli, MD John McMechen, MD Richard Daugherty, Migrant Program Coordinator

A. PURPOSE OF VISIT

This visit was, in part, preliminary research for a needs assessment on migrant farmworkers' health needs for the state of Tennessee. The visit covered three clinics in eastern Tennessee which are currently providing health care to migrants (migrant farmworker(s) will be referred to as *migrant(s)* throughout this report). These clinics are officially recognized by the U.S. Public Health Service as migrant health centers as defined in the 1994 Migrant Health Centers Referral Directory.

The primary goal of the visit was to seek health care providers' and other social service providers' opinions and perceptions of migrants on the issues outlined below. The data were collected through semi-structured and informal interviews and short survey. Instrument guides for the semi-structured interviewing and survey are available upon request.

B. ACTIVITY

The most prominent issue is (1) *migrants' critical health needs*, and secondary issues are: (2) problems providers encounter in providing health care to migrants, (3) country of

origin of migrants, (4) primary language of migrants, and (5) where migrants live when they are not working in Tennessee. *Cultural and geographic origin* information on migrants is critical to understanding the health care needs of migrants because culture and language affect these needs.

Issues 1 and 2 were collected through semi-structured interviews. The data for issues 3, 4, and 5 were obtained by survey. Thirteen people (4 males and 9 females) were given a short survey to fill out. Of the people surveyed, the length of time they have worked with migrants ranged from one (1) year to over twenty-five (25) years. The average length of time the respondents have worked with migrants is 6.3 years. When the one person who has worked for more than twenty-five years with migrants is deleted, the average is 4.6 years.

1. Critical Health Needs

CRITICAL HEALTH NEEDS
(46 Responses from 18 People)

NEEDS	# CITED	NEEDS	# CITE
acute care	1	improved nutrition	1
alcoholism	2	infectious disease	4
asthma	1	lead screening	1
back injuries (occupational injuries)	1	learn English	3
chemical exposure at work	3	mental health	1
child health care education for parents	2	multiple pregnancies	1
delayed treatment/need for earlier treatment	2	need for translators	1
dental care	5	nutrition education	2
diabetes	6	occupational injuries	3
ear infections (children)	2	orthopedics	1
epilepsy	1	pediatrics	1
eye care/eye glasses	1	pesticide education	2
family planning	1	pre-natal care	7
GI problems due to poor nutrition	1	preventive medicine	2
GYN care	1	social services	1
health education	5	specialty care	1
hearing impairments	1	spouse abuse	1
heart disease	1	STD education	3
high risk OB	1	STDs	3
housing	4	TB education	3
hypertension	3	TB	1
immunizations	4	well baby care	1
impetigo	1	working conditions	1

Table 1 Migrants' Critical Health Needs and Total Number of Responses

Eighteen people (N=18) were asked, "What do you think are the most critical health needs of your migrant population?" Forty-six (46) responses are identified. The results are listed in Table 1.

a. Leading Themes (see Table 2)

1. Health education is the leading theme of the forty-six (46) responses with seventeen (17) responses. Health education in general or named by specific topic (e.g., tuberculosis education) represents 37% of all identified responses.

2. The next most prominent theme is infectious diseases with nine (9) responses representing 19% of all identified responses,

3. followed by occupational health and

4. pre-natal care with eight (8) responses each.

5. Diabetes with six (6) responses and

6. dental care with five (5) responses were seen as significant health needs of migrants. Chronic diseases such as hypertension with three (3) responses and heart disease with one (1) response were also listed as critical health needs of migrants.

Themes	#1 Health Education	#2 Infectious Disease	#3 Occupational Health	#4 Pre-natal Care
Responses and # of Citations	child health ed. (2) general health ed. (5) nutritional ed. (2) pesticide ed. (2) STD ed. (3) TB ed. (3)	impetigo (1) infect. disease (4) STDs (3) TB (1)	back injuries (1) chemical exposure (3) occupational injuries (3) working conditions (1)	high risk OB (1) Pre-natal care (7)
Total # of Citations	17	9	8	8

Table 2 Most Significant Themes of Critical Health Needs

b. Preventive Health versus Curative Care

Nearly one half of the responses (21 out of 46) can be categorized as preventive health care measures versus curative care (see Table 3). Twenty-five (25), or 52%, can be categorized as curative care.

Preventive Health Responses (21)	
child health education	learn English
delayed treatment/need for earlier treatment	need translators
	nutrition education
dental care	pesticide education
family planning	pre-natal care
health education	preventive medicine
high risk OB	social services
housing	STD education
immunizations	TB education
improved nutrition	well baby care
lead screening	working conditions

Table 3 Forty-five percent (45%) of all responses relate to preventive health measures.

c. Critical Health Needs and Language

Three (3) respondents cited language as a critical health need, which was more frequently cited as a *problem* (discussed below) in providing health care to migrant patients, not a health need. These three people saw language as the first critical step in obtaining health care needs, and, therefore, a critical need. One person explained:

> They come to the hospital--there's no one to translate for them. They can halfway get themselves through the first stage, but when the doctor comes to ask for more specific information, they're lost. And they [can] give only so [much] and the doctor can do only so [much]. . . .

When asked what are the critical health needs of migrants, another person said, "First they are going to have to learn [the English] language. I think that they need that. . . . They don't understand a lot of the medical things that go on." A third person said translation services take up a lot of time--evenings and weekends, not just during "working hours." This person added, "English is a major need [for migrants]."

2. Problems Faced in Providing Health Care to Migrants

Thirteen people (N=13) were asked "What problems do you face in providing health care to migrants?" Twenty-seven (27) responses were identified. They are listed in Table 4.

PROBLEMS FACED IN PROVIDING HEALTH CARE TO MIGRANTS
(27 Responses from 13 People)

PROBLEMS	# CITATIONS	PROBLEMS	# CITATIONS
adherence to folk remedies	2	migrants "settling-out" place more demands on the medical system	1
confusion with last names	1	no night clinic	1
delay of treatment	4	non-compliance	1
different culture	1	poor historians (for medical histories)	1
dispersed populations	1	referrals/specialty care	2
follow-up care	3	scheduling appointments	2
funding	2	scheduling health education classes around migrants' work schedules	1
higher clinic fees	1	self medicate with medicines brought in from Mexico	1
high cost of health care	1	site to host a free dental clinic for migrants	1
lack of continuity of MDs from year to year	1	Tenn Care	1
lack of immunization records	1	transportation	2
lack parenting skills	2	walk-ins	2
language	9		
low education	1		
low comprehension of instructions	2		

Table 4 Problems Faced in Providing Health Care to Migrants

a. Leading Themes (see Table 5)

Of the twenty-seven (27) responses, three salient themes are identified: cultural differences, economics, and language.

1. Cultural differences is the most prevalent theme of all the cited problems health care providers face in providing care to migrants. I have separated the issue of language from cultural differences in order to underline that providers perceive language to be a major problem in providing health care to migrants. The survey results (discussed below) further supports this finding.

2. Economics is the next prevalent theme with thirteen (13) citations. Two (2) people specifically reported difficulty getting migrants referrals for hospitalization and to specialists due to lack of funding. One person gave his opinion of funding with two examples:

> We try to make sure that we deal with pregnant ladies, but that . . . is a problem between the hospitals because a lot of them [female patients] are from another county. And the hospital says, 'hey, wait a second. We can't be doing charity work for another county.' And it does fall out of the cachement area basically of the hospital.

Themes	#1 Cultural Differences	#2 Economics	#3 Language
Responses and # of Times Cited	folk beliefs (2) last names (1) delay of treatment (4) differnet culture (1) follow-up care (3) parenting skills (2) low education (1) low comprehension of instructions (2) non-compliance (1) poor historians (1) self medicate (1) walk-ins (2)	funding (2) higher clinic fees (1) high cost of health care (1) more demands on medical system due to settling-out (1) referrals/specialty care (2) scheduling appointments (2) site for free dental clinic (1) Tenn Care (1) transportation (2)	language (9)
Total # of Citations	21	13	9

Table 5 Most Significant Themes in Problems Providing Health Care to Migrants

The person continues:

> The adults get sick and where is the responsibility? What about if someone, we identify someone who has a tumor? Should we be saying, 'look you really need to go back to Mexico. It's the responsibility of your health system.' Or should we be saying, 'yeah, we'll be doing the whole thing. We'll run up a fifty thousand dollar hospital bill that no one's ever going to pay.' I don't know. I can't answer some of these questions.

3. Language

The majority of people interviewed (9 out of 13) reported that language is a problem in providing health care to their migrant populations. The four people who did not cite language as a problem are fluent Spanish speakers. Several Spanish speaking providers stated that they were overwhelmed with translating duties. In one clinic area, there has been cases where, at times, hospitals will not accept patients unless the clinic can provide translators for the medical staff. Language will be discussed below in relation to the survey results.

3. Migrants and Country of Origin (see Table 6)

Thirteen (13) people were asked in survey form, "In your experience, what countries do the migrants come from?" Thirteen countries or regions were identified by those surveyed.

COUNTRY OF ORIGIN ORDERED BY THE NUMBER OF TIMES IT WAS CITED			
Mexico	13	Alaska	1
Guatemala	6	Asia	1
Cuba	4	Haiti	1
El Salvador	4	Dominican Republic	1
Honduras	2	Nicaragua	1
Russia	2	Puerto Rico	1
USA	2		

Table 6 Country of Origin Ordered by the Number of times it was Cited

Mexico is the most frequently cited country of origin with thirteen (13) citations, followed by Guatemala with 6 citations, then by and Cuba and El Salvador with four (4) citations apiece. Two people from different clinic sites listed Russia as a country of origin for migrants. These data suggest that Russian migrants have been sighted in at least two different regions of eastern Tennessee.

4. Monolingual Migrants (see Table 7)

Nine (9) of the thirteen (13) people surveyed reported working with migrant patients who could not speak English *nor* Spanish, or who were monolingual. These monolingual migrants, according to the respondents, come from six (6) countries.

COUNTRIES OF ORIGIN OF NON-ENGLISH, NON-SPANISH SPEAKING MIGRANTS	
Mexico	Haiti
Guatemala	El Salvador
Honduras	Russia

Table 7 Countries of Origin of Non-English Speaking, Non-Spanish Speaking Migrants

5. Where Migrants Live When Not in Tennessee (see Table 8)

People participating in the survey were asked, "When the migrants are not working in Tennessee, do you know where they Live? Please comment." Florida and Texas were the most frequently cited locations. Five people reported that some migrants live all year in Tennessee.

LOCATIONS OF MIGRANTS WHEN NOT WORKING IN TENNESSEE

Location	Number of Times cited
Alabama	1
Florida	13
Mexico	1
Texas	9
Virginia	1
some live in Tennessee all year	5

Table 8 Locations of Migrants When Not Working in Tennessee

C. RECOMMENDATIONS

• Health Educators and Health Education

The data suggest that health educators and a broad spectrum of health education are needed in the clinic setting. In addition, I recommend that health educators work within the migrant communities to reach migrants before they need the services of the clinic and to target those migrant who do not use health facilities. Since the focus of this research was not the migrants themselves, the number or percentage of migrants who do not utilize these clinics or whom have no access to an approved clinic is still an unknown but see the recommendation for further research below. The health educators will need to work in conjunction with English teachers as well as facilitators in the community who can instruct migrants in appropriate ways in which to survive in our American culture. The health educator might possibly serve as a pivotal figure in the community around whom the migrants and various parts of the health care system could interact.

• Appropriate Cultural Training for Health Care Staff and for Migrants

Peoples from Latin America and the Caribbean differ culturally from peoples of the United States, especially if they come from rural areas. The data suggest that some health care workers do not understand the culture of their patients and that many migrants do not understand the culture of the United States, and specifically the culture of the United States medical system. The majority of problems health care providers cited in providing care to migrants are cultural problems. Health care providers and social service personnel need an understanding of the peoples with whom they provide care in order to provide efficient and effective care. Issues of patient non-compliance, low comprehension of instructions, differing perceptions of health and illness are culturally determined and have different meanings in different cultures. Many Mexicans, for example, may not consider themselves sick if they can get up, get dressed, and walk to the fields. It is only when they

are unable to physically work that they may consider themselves sick, warranting medical care. Two-way cultural classes, for health care providers and for migrants could provide a better understand and relationship between health care providers and their patients.

- **English Language Classes**

All three sites had persons who voiced their opinions that one of the most crucial needs of migrant farm workers was to have a basic command of the English language. All aspects of the migrants health can be and are affected by their ability to communicate and understand their alien environment. By providing English as a Second Language classes, the migrants will become empowered to be able to make decisions and therefore take charge of their health. This should lead to a reduction in health costs by many routes such as a reduction in occupational injuries due to understanding and comprehension of their work environment and its potential dangers, or a reduction in visits to hospital emergency rooms because they should be able to feel safe in visiting health clinics or seeking other less expensive ways of receiving medical treatment. Another route will be their ability to improve their living conditions and thereby reducing preventable health problems caused by inadequate housing, food, water, and sanitation.

- **Further Research**

There is a desperate need in the migrant's lives for many basic changes all of which pertain to health care. Items such as adequate housing, food, water, and sanitation, protection from occupational injuries and exposure to pesticides, and affordable access to Primary Health Care in the U.S. are examples of the types of issues that are directly impacting the families of migrants in Tennessee, and yet we have little idea of how profound these problems are. We need to find out how many migrants there are in Tennessee during the different growing phases of the year. We need to know what migrants perceive to be their medical needs and, also, to see how and where they are currently receiving their medical treatment. We need to get a solid idea of their migratory patterns and their stability patterns. There needs to be an examination of migrant health beliefs, fears and their understanding of our medical system. The most efficient way to reduce costs in medical care for this population upon whom we are very dependent is through primary health care, yet Tennessee has only three clinics in the entire state that provide health care to migrants. There needs to be more clinics throughout the state providing preventive care for migrants and their families. This is the most cost effective method of providing the migrant population with basic medical care and keeping them out of hospital emergency rooms. We have few facts about the multiethnic population that we wish to provide care for. The basic questions of who are they, what do they need, when can they access it, where should clinics be located for the best access, and how many of them there are, must be answered in order to provide the minimal adequate health care to this population.