NEW DEVELOPMENTS IN IMPROVING CONDITIONS FOR MIGRANTS

Notes on talk presented by Helen L. Johnston, Public Health Service, HEW, at National Farm Labor Conference

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The agenda lists as the topic "New Developments in Improving Conditions for Migrants." What we're really talking about is improving migrant-community relations.

In the past migrants have feared possible inability to obtain needed health care in an emergency especially while they were in strange communities. The community, on the other hand, feared that the migrant worker or a member of his family would become ill and become dependent on the community as a result of a health problem.

At times, Farm Labor Service representatives have dug deep into their own pockets to help migrants pay for emergency care needed as the result of sickness or injury. Other individuals and groups in local communities have also come to the rescue in emergencies.

This type of unplanned, often involuntary, and sometimes reluctant charity is hardly a reasonable or satisfactory approach to meeting the health problems that migrant workers and their families inevitably suffer as they move from one work community to another. Nor does this approach contribute to good migrant-community relations.

A new approach became possible in 1962 with the passage of the Migrant Health Act. The purposes of the Act were simple--to help migrants gain realistic access to needed health services in their temporary communities and learn how to use these services wisely; and to help

communities assume responsibility for extending community health service to migrants while they resided in the local area.

The Act enabled the Public Health Service to make grants to public or nonprofit agencies to pay part of the cost of setting up and operating family health service clinics, or of providing other services to improve migrants' health conditions.

At present 69 projects are receiving grant assistance in 33 States. Projects range from single-county operations to Statewide organizations serving most or all of the counties in a State with a major influx of seasonal farm workers and their families. The projects are planned, developed and conducted by the community at the point where services must be delivered if they are to reach the migrant. They mobilize the resources of public and private agencies in a concerted health effort.

The typical project operates family clinics, usually at night, located in or near a large labor camp or other migrant concentration point. Sometimes the clinic is housed in one of the dwelling units in a camp. Physicians, dentists, and nurses are present to diagnose and treat whatever conditions are presented, to provide immunizations and other preventive services, and to teach migrants how to improve their personal health practices. The clinic sessions are supplemented by the services of public health nurses who visit families in the camps, find out about their health needs and make referrals to family clinics or other sources of health care, visit again after a migrant has seen a doctor to see that instructions are understood and followed, and advise families generally on good personal and family health practices.

Project sanitarians help to eliminate the unhealthy environmental

conditions that often give rise to needless illness. They inspect farm labor housing before the season opens and work with growers to bring it up to required standards. During the season, the sanitarians continue to work with owners and occupants of the housing to see that it is maintained at an adequate level to avoid risks to health and safety. They continue to be concerned with the housing after the season is over if some families linger on rather than immediately moving on. In many localities, their work is essentially a 12-months' job including preseason inspection and surveillance during and after the season.

Usually the projects have the services of a health education consultant available on a full or part-time basis. This consultant may work with project health workers and volunteers to help them do a more effective job of teaching migrants to live in a healthful, safe way. Or he, himself, may also engage in direct work with migrant families.

The majority of migrant health projects have established working relationships with other public and private groups and individuals in the community in order to extend their service effort. Many involve community volunteers in working as receptionists at night clinics, providing patients transportation, preparing makeshift quarters for use as clinics, and other ways. Through these working relationships, people from the community and people from the migrant camps have been brought together in a meaningful way--sometimes for the first time. From this is growing better migrant-community understanding and relationships.

Many opportunities exist for joint working relationships between the Farm Labor Service and health workers involved in migrant health projects. Probably the most frequently observed relationship is in fulfilling the health workers' need for information about the population to be served. The Farm Labor Service has data on arrival and departure dates, and on numbers of workers and family members that can be expected, which are invaluable to State and local project directors in planning a health program.

We hope through working together in the next few months that the county-level data we have been using at our national headquarters for the last half-dozen years can be brought up-to-date and improved. This contribution by the Farm Labor Service is one that is greatly appreciated since health agencies are not set up to collect systematic data on migratory farm labor families.

The opportunities for cooperation are not just a one-way street, however, with all the benefits flowing in the direction of the health worker and his agency. Some communities in farm-labor demand areas have prepared brief summaries of project services which could be made available for attachment to job orders sent to labor-supply areas. Further development of such summaries could be encouraged. We already have evidence that the knowledge that health and other services are accessible is an added incentive to a worker to go to a particular community.

Migrant health projects in home-base communities have as one of their

objectives helping to prepare people to move. Farm Labor Service representatives in the north would serve their own needs for workers in good health as well as the needs of the farm workers, if they urged returning migrants to visit health projects when they get back home and obtain physical check-ups, treatment, immunizations and other services to protect their health when they once more leave home.

The sanitarians working in migrant health projects are a natural ally of Farm Labor Service people. Close cooperation in some areas is already leading to good results in improved living and work environment. There are wide opportunities for expansion of such effort.

The familiarity of the "fringe benefit" concept to labor people would make them helpful to health workers in gaining greater community acceptance of migrant health projects. Fringe benefits, including health service benefits, have long been accepted for industrial workers. Employer-worker arrangements and relationships in seasonal agriculture highly dependent on migratory workers make it difficult if not impossible to develop a fringe-benefit program. Why should a program in which the local, State and national community share responsibility for provision of health care to migrant workers and families be looked upon as "charity?" Why not, rather, look upon it as a program to aid agricultural producers to extend fringe benefits to their workers in a situation which limits the individual employer's ability to do so? Then the worker who is the beneficiary can accept the service in dignity as a right he has earned, rather than as community charity.

In conclusion, to help realize some of these possibilities, Farm

Labor Service people will find an able ally in the Migrant Health Representative on the Public Health Service staff serving each of the Regional Offices of the Department of Health, Education and Welfare. In each State, also a contact person on matters relating to migrant health has been named by the State health officer. Finally, we ourselves look forward to continuing cooperative relationships with your headquarters office in Washington. This is certainly no new development, but one that we value highly and hope to continue and expand.