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Violence in Transience: Nursing Care of Battered Migrant Women.

Violence in Transienc of Battered Migrant Women

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Nurses working with migrant farm worker women face serious challenges. Poverty, language, and cultural differences between farm worker women and health care providers present substantial barriers to women obtaining access to the health care system. These differences are especially important in instances of domestic violence. The transient life style of migrant farm workers, combined with geographic and social isolation, make it especially difficult for health care providers to meet the needs of migrant battered women. Strategies for working with migrant battered women are offered.

THE MIGRANT LIFE STYLE

Little has changed for migrant farm workers during the last 30 years. Their living and working conditions remain among the most hazardous in this country. Exposure to pesticides, extremes of weather, and overcrowding are just a few of the harsh realities of migrant life (Wilk, 1986).

A migrant farm worker is described by the federal government as, "an individual whose principal employment within the last 24 months is in agriculture on a seasonal basis . . . and [who] establishes a temporary abode for employment purposes" (Migrant Health Program, 1992). Traveling thousands of miles each year, migrant laborers work in the fields and live in labor camps that usually are located on the grower's property. Life in the camps is particularly difficult for women. It is estimated that 70% of married women work in the fields with their husbands (Smith & Gonzalez, 1992). After these women work 10 to 12 hours in the field, their work day continues with housework and child care. Women often mention being tired and having no time to rest. These long work days preclude much interaction with other women in the camps. Describing life in the camps, one woman stated, "you rarely see women talking to each other. There is no time to worry about the other person" (unpublished data, Rodriguez, 1992).

EFFECTS ON HEALTH

Documentation regarding the health status of migrant farm workers is lacking. Although there is regional and anecdotal information suggesting that farm workers are at risk for poor health, there is a paucity of reliable research data. The studies that exist include epidemiologic studies of infectious or chronic disease and medical use patterns (Dever, 1991; Arbab & Weidner, 1986; Chi, 1985).

Data regarding pregnancy outcomes and infant mortality also are scarce. A study in California (Slesinger, Christensen, & Cautley, 1989) found an infant mortality of 30 per 1,000 live births among migrant farm workers, compared with 14 per 1,000 in the general population of the United States. This same study reported a mortality of 46 per 1,000 migrant children younger than 5 years. De la Torre & Rush (1989) found that 24% of women in their sample (n = 148) experienced one or more miscarriages or stillbirths. This was comparable to the findings of simi-

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lar studies cited by the authors in San Diego and Tulare counties that reported miscarriages and stillbirths for migrant women of 28% and 31%, respectively. A survey of migrant farm workers in Colorado (Littlefield & Stout, 1987) documented 32.5% of their sample (n = 120) experiencing at least one miscarriage or abortion. Infant mortality for this sample was 12.5%.

Anecdotal information abounds regarding the prevalence of domestic violence among farm worker women. Nurses working with migrant farm workers and the women themselves talk frequently about the problem. Although it has been identified as a priority by those working with migrant farm workers (Migrant Clinicians Network, 1992), the prevalence of battering among this population remains unknown.

UNIQUE RISKS FOR THE MIGRANT WOMAN

Reaching the battered migrant woman presents a particular challenge to nurses. There are a number of factors that affect nurses' ability to reach and assist farm worker women. The *transience* of the migrant worker's life style provides nurses with limited time for contact. Women may stay in one area for as little as 1 week, depending on the availability of the work. Sometimes women are able to live in one camp for 3–5 months.

Isolation is another important factor that must be considered when planning nursing care. Not all farm worker women live in labor camps in close proximity to other families. In some parts of the country, migrant housing is scarce and workers must locate housing. This may be a motel room in town or a trailer away from main roads. For the most part, there are no telephones and limited access to transportation. The woman must depend on the family automobile to get to a commercial laundry, grocery store, or clinic. These often are not close; sometimes more than 1 hour of transportation time is needed. If the woman does not know how to drive, she is dependent on her partner (or other family member) for transportation. The battered woman may have no way out of a dangerous situation.

Not only are these women geographically isolated, they may be socially isolated, even within the camps. One farm worker woman stated, "Women have problems among themselves; there is gossip; women don't talk to other women" (unpublished data, Rodriguez, 1992). This self-imposed isolation can make it extremely difficult for a woman who is being battered.

Migrant farm workers are a multiethnic group. Hispanics make up the largest segment (60%), with most of these being Mexican or Mexican-American. Central Americans, Haitians, and African-Americans also are among those doing farm work throughout the country (Zuroweste, 1991; Office of Migrant Health, 1992). Given the differing cultures and values inherent in working with this population, nurses must develop an understanding of and sensitivity to the *language* and *culture* of the farm worker women with whom they are working. This is especially important in the area of domestic violence.

IMPLICATIONS FOR NURSING

Nurses working in migrant health must make a commitment to learning the primary language of the farm worker woman. Although the women may understand and speak some English, nurses must consider that clients may prefer to speak their native language, especially in times of stress, such as living with the threat of violence. Even if a translator is available, speaking of an issue as sensitive as intrafamilial violence through a translator may violate the cultural values of the migrant woman.

Sensitivity to culture must underscore any intervention with battered migrant women. Before the nurse can speak openly with the migrant woman about the options for dealing with the violent situation, she must be accepted. For example, the traditional mainstream ideal of professionalism may be perceived as cold and distant by Hispanics. For the nurse to be effective with a Hispanic woman, she must quickly demonstrate *confianza y corazon*, a warm, accepting attitude and a warm, accepting heart. These two qualities are the cornerstone of an effective relationship with an Hispanic woman. Once the woman feels secure with the nurse, options and strategies can be discussed.

Cultural sensitivity is important to all aspects of health care, but for the migrant woman it is critical. For the battered migrant woman, it may be a matter of life and death. Given the migrant woman's geographical and social isolation, the nurse may be the only source of support. The transient nature of this life style calls upon the nurse to be able to quickly develop a trusting relationship with clients.

Even in the best of circumstances, a migrant woman may be hesitant to discuss the issue of violence in her home. For example, I am Hispanic, speak fluent Spanish, and am a native of South Texas, but I had a difficult time getting the women to open up about the violence they were experiencing. Identifying the proper way to assess for violence (eg, *how to ask the question*) took several months. Trial and error with questions such as, "Has anyone ever hurt you?" or "Are you afraid when you argue with your husband?" met with negative responses. Women would say that they did not have a problem with violence in their homes. After several versions of assessment questions were attempted and failed, I decided to use a new approach. The women were asked what they would tell the nurse to tell a woman who may come to her as a result of physical abuse by her partner. This "third person" approach finally met with great success. Women who previously had denied physical abuse repeatedly offered information regarding how they handled their abusive situations.

Another important consideration for nurses working with battered migrant women is the need for *outreach*. Migrant health clinics are located in areas with high concentrations of farm workers. There are more than 400 clinic sites, but these clinics are reaching only about 12–15% of the country's 3–5 million farm workers (Migrant Clinician's Network, 1992). Although many reasons are given for the small numbers of farm workers using migrant clinics, such as transportation, language, and working hours, nurses must remember that in many cases women are *not allowed* by their partners to seek health care services.

In a recent ethnographic study (unpublished data, Rodriguez, 1992), migrant women have reported that men do not allow them to seek health care. Common statements include, "there's times when they're really sick [the women] and they need to go to the doctor, but their husbands just really don't want them to" and "the husband won't let them because he doesn't want them to and he doesn't have time and won't give them permission and if she doesn't have permission, she can't go." It is proposed that this form of abuse, denial of access to health care, may be more common than the physical abuse described by many farm worker women.

STRATEGIES FOR INTERVENTION

Social support through outreach is critical for nurses working with battered migrant women. Since the women move so frequently and live in remote areas (often without telephones), it is imperative that the nurse make frequent home visits. Missed clinic appointments should signal the need for a home visit.

If the woman has been migrating to the area on a fairly regular basis, she may be able to predict the next stop on the migrant trail. At the very least, she may have an idea about what state may be the next stop. With this information, the nurse can give her the names of shelters in the general area. A state-by-state directory of shelters and other services for battered women is available from the National Coalition Against Domestic Violence in Denver, Colorado.

In addition, the woman should be given the locations of migrant health clinics. These are available through a state-by-state directory of migrant health centers available through the National Migrant Resource Program in Austin, Texas. The name of a contact person (ie, nursing director) and the telephone number of the clinic would be particularly helpful. Although the woman may not have access to a telephone in her home, she may be able to use a pay phone while traveling.

CONCLUSION

Migrant farm worker women face many of the same barriers to health care encountered by other disenfranchised populations. They also share with urban battered women many of the same obstacles to access to health care. In addition, migrant farm worker women are constantly moving. This transient life style

presents unique challenges for nurses to develop practical, workable strategies for providing nursing care to this high-risk population.

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