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Community Health Nursing in Migrant Farm Camps

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The author describes a community health nursing experience in the migrant farm camps of south Georgia. While providing primary healthcare to an underserved migrant farm community, students began to understand the complexities of health, policy, and community organization. Examples are presented that reflect crucial elements of student involvement and barriers to learning.

The undergraduate community health nursing course in our undergraduate program had been structured after guidelines from the Association of Community Health Nurse Educators. Content was addressed in a 10-week, eight-quarter credit course that consisted of three didactic credits and five clinical credits (3 classroom hours and 10 laboratory hours/week). The primary clinical agency was the public health department. There were two course themes—community assessment/epidemiology and family assessment and advocacy. By the end of the course, students were expected to have completed a community and family assessment and actively pursued a legislative issue relevant to nursing practice.

However, the nursing faculty members perceived that primary and preventive healthcare is becoming a model of practice for healthcare reform. Thus, nurse educators need to develop creative learning opportunities for students. To this end, the author developed a community clinical experience that would immerse the students in a community and its culture. The author hopes to communicate the holistic perspective of nursing practice in such an experience through the use of narratives.[1]

Description of the Immersion Experience

Migrant farm camps were chosen as the location for the experience because education is not always sensitive to minority cultures and migrant workers and their families frequently have met healthcare needs that are not met.[2,3] The faculty felt the experience would provide students with a transcultural nursing environment unavailable to them in other more traditional settings. The goal of this experience was to assess aggregate healthcare among migrant farm workers and their families while providing students with an innovative learning experience that gave them an opportunity to practice primary, secondary, and tertiary care using a culturally sensitive framework.[4] Rationale for introducing this experience included 1) providing an innovative transcultural learning program for students[5]; 2) creating a problem-based, experiential, learning experience[6]; and 3) developing a community partnership between the migrant farm community, health providers, and the nursing community.[7–9]

Eleven nonlicensed undergraduate students elected to complete their required community health course during the summer by working with migrant farm workers and their families during 13 consecutive days in June. Excluding tuition, the average cost paid by each student was $300, which included housing, food, gas, and personal expenses. Students lived in dormitories at a small college near the migrant camps. Most of the students used vacation time from work to participate in this experience and were delighted to pay these expenses to complete a 10-week course in 2 weeks. Students were selected based on their grades, references, motivation, and commitment to the project.

Students in this experience were encouraged to participate in course development, implementation, and evaluation during the planning phase. Beginning in January, students met informally with faculty members at various times to discuss course content, clinical and didactic times, and methods of evaluation. Having students share responsibility for a course enhances clinical competence, motivates both instructor and student, facilitates problem-solving, and increases productivity and learning.[10,11]

Can family and community content be synthesized in a period of just 2 weeks? This issue was partially resolved with the introduction of four, 2-hour class periods before the experience. Content focused on history of public health nursing, community assessment, and family and cultural dynamics. Additionally, an independent study epidemiology/biostatistics module developed by the Centers for Disease Control Home Study program was completed by the students. Six hours of clinical time and 3 hours of seminar were scheduled during the 13-day experience. To supplement the students'

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knowledge of this minority community, students also rotated either a half-day or full-day through a public health department, attended a statewide retreat on rural health, and performed physical examinations on school-aged children of migrant workers.

Five migrant camps within a 25-mile radius of the primary health center were selected for this experience by the migrant health director. The initial assessment project provided data on 225 men, women, and children in the camps using interviews, observations, and health records. Few of the adults spoke English; all the children were bilingual. With income dependent on picking crops, the migrant community generally only sought emergency healthcare. One of the goals of this experience was to provide primary nursing care to the workers and their families.

Faculty concerns related to meeting the overall objectives of the experience included the following: 1) will students be exposed to comparable learning situations to that of students who enrolled in the traditional course; 2) would physical and emotional stressors inhibit learning; 3) can language and cultural barriers be overcome in providing direct nursing care; 4) can key conceptual content be taught in such an experience; and 5) will ethical and liability issues adversely affect learning? The advantages and disadvantages of the experience in meeting course objectives follow as each of the concerns is addressed.

Comparable Learning Situations

Initially, two assessments were planned for the course—prenatal care and barriers to care (i.e., transportation, financial, and health belief systems). Although considerable planning had gone into each of these two assessments, the prenatal assessment was discontinued several days into the experience because very few pregnant women were in the migrant camps. Barriers to care identified in the initial assessment took on a new perspective when students initiated a mass screening for tuberculosis.

For example, while reading the induration of tuberculin injections, students became increasingly concerned that neither follow-up nor treatment was available to this group of workers. One worker with a positive reaction asked if it was all right to continue sleeping with his wife. Others wanted to know if it was safe for a fellow migrant to sleep in the same house. These and other questions prompted an in-depth discussion among the students on the World Health Organization ethics of screening; this lasted several hours one evening. Students decided to act on behalf of the migrant farm workers and their families by writing to state and federal officials and insisting on a mobile van for chest x-rays and allocation of money for follow-up treatment. Several students later attended a conference on rural health and presented their findings to the state and national officials.

The experience prompted learning that could not have been achieved in class during a structured period. Had the students received this information in a traditional setting, would they have integrated the content into the experience? These baccalaureate students found themselves participating in the multiple issues surrounding screening, including calculating appropriate rates and ratios of the prevalence of communicable diseases and chronic health problems, analyzing health policy for disenfranchised populations, and modifying approaches to decision making. Limited economic resources also became a critical element for consideration. Students began to understand the impact that professional nurses make, and must continue to make, in local, state, and national health policy. In caring for this migrant community, these students became cognizant of the complexities of health issues and advocacy, and second-order change became real concepts, not simply words in a textbook.

Physical and Emotional Stressors

Two paramount stressors for the students became evident during the course of this experience. First, stress was placed on students to learn new content in an abbreviated period of time under less than optimal conditions (i.e., no classrooms. desks, air conditioning). The second stressor was the possibility of exposure to unsanitary and even dangerous living conditions, such as pesticides and mosquitoes.

Faculty members were concerned that the intensive time requirements placed undue physical and emotional strain on the students. Initially, students were to work with migrant farm workers from 8:00 AM until 2:00 PM, and have class in the evening. However, after providing extended care for the workers and their families during the day, students developed strategies to find extra time for class, i.e., small group seminars. To discuss the day's agenda and prepare for the next day, students frequently extended class until late in the night. Clinical conferences often were held in the migrant camps during lunch. Physical and mental stressors were significant, but the energy generated by the experience sustained and fueled the group's commitment.

The second stressor also concerned the faculty members. Some of the living conditions that the students found were not only unsanitary, but dehumanizing. As many as 12 people (three families) lived in a single-wide mobile home without air conditioning. In addition, while providing nursing care out in the fields, where do students go to the bathroom? Migrant farm workers in the fields do not have access to portable toilets. Female migrant workers who lack privacy in the fields often do not empty their bladders frequently. These women often would not drink enough fluids to avoid dehydration in the hot Georgia sun. Consequently, urinary tract infections were the most common occupational health injury among the women. These stressors and their impact on the students can best be illustrated in the following scenario.

Imagine driving into a migrant camp where, 24 hours earlier, people had indicated that they needed no healthcare; the students felt unwanted. This time, the same caravan pulls up; but this time, they were surrounded by women, children, and young men. Everyone wanted something done for them—even kids were

velling for their shots with arms outstretched. Women and men surrounded the station wagon, almost a party atmosphere. What was the reason for this change in behavior? Was it their perception that the students cared? The fact that the services were free? Regardless, the caravan stayed until 9:00 PM. A woman with a diastolic blood pressure of 110 who would be working in the fields the next morning opened up. An older man wanted advice on the poor circulation in his legs. Clearly, students were sustained by knowing that they were making a difference in these people's lives. Concepts of resource allocation and the necessity for triage became critical elements of their learning. The students believed that the long hours with the migrant workers in the hot sun was worth the effort; they accomplished something that they personally chose to do, rather than something they were required to do.

Cultural Barriers

Can a family and community assessment be completed with limited knowledge of the population's language? Fortunately, we had one Spanish-speaking student and a part-time translator whose family members were migrant workers. We also communicated using the children as translators, and by nonverbal communication. Caring transcended the language barrier. By attempting to eliminate our cultural bias and make a commitment to the community, we were well received and treated as partners within this community. Our persistent and genuine intention to support this community's efforts to enhance their healthcare overcame feelings of mistrust toward outsiders. Heightened sensitivity to multicultural content enhanced our acceptance into this disenfranchised migrant community.[12]

Integrating Conceptual Content

Students had to find creative solutions to complex problems within themselves, their peers, and the limited available community resources. Undergraduate textbooks generally are written to cover broad issues, attempting to generate solutions to the multiple dilemmas students experience in a variety of settings and cultures. Limited information on migrant health practices is available in community health nursing textbooks.

The following example demonstrates how these students learned.

A 32-year-old, well-developed man came to the clinic suffering from dehydration and nausea. Through an interpreter, we learned that the crew leader would not allow the men to interrupt their work to go to the bathroom and that he feared for his safety because he had come to us. Further, the crew chief was withholding his pay. A visit that evening to the worker's trailer revealed that 16 other workers were living in one trailer, and they shared a bathroom with two other families. On this visit, we advocated to both the crew chief and with local officials to collect the wages that were due the worker. Then, we took the man to another camp so that he would not suffer recriminations from reporting the squalid conditions to the authorities. Later, he told us through an interpreter that his wife had died and he was supporting his four children by picking crops in the United States.

In addition to advocacy for this client, students contacted several state and federal agencies to report on the substandard living conditions. This action necessitated learning the legislative and political process, including the hierarchy of control between state and federal jurisdictions. Letters were written to state officials and students attended a rural health outreach forum to discuss overlapping issues of health, labor, and migrant farm policies. Farm owners became more positive toward the experience after being informed by students the costs of emergency healthcare to their rural community and the diminished output of workers who were too ill to be productive.

Ethical and Liability Issues

Several questions on ethical and liability issues arose during the course of the experience. Can students transport community members to health clinics? What are the concerns if students become ill because of events that occur during the experience? What are practice limitations in the absence of appropriate healthcare providers? When does a community visit end and socialization begin in such an experience? Students and faculty members were required by the university to have malpractice insurance, and the university attorney approved the consent forms for student participation. Other ethical dilemmas experienced by students and faculty members could not be resolved so simply. The following situation provides an example of one such dilemma.

A young woman asked us to inject her with medroxyprogesterone acetate (Depo-Provera, Upjohn, Kalamazoo, MI) to prevent pregnancy. She received the medication from Mexico and had ready access to a tuberculin syringe. The nurse practitioner stated that because there was a chance she was pregnant and that the drug might induce fetal complications, but not necessarily an abortion, it should not be given. Using the syringe also could result in a serious abscess. The young woman did not want to inject herself, but was determined not to become pregnant or to take birth control pills for 30 days. The students had to decide their responsibility as primary care providers, and a decision was made not to give her the syringe but to counsel on a daily basis.

Students and faculty members decided that in certain situations, we would transport clients to healthcare facilities. Because no student became sick during the experience, issues of course completion were not addressed. Decisions were made based on a balance of the ethical need to provide an essential service and the legal policies of students within a university program.

Summary

An immersion experience provides students with a unique opportunity to assimilate complex information about culture and health that would not be available otherwise. Student evaluations of the experience were

exceptionally favorable. For example, a student stated on her evaluation:

> For the first time since I started this nursing program, I actually feel like a real nurse. Being out there, doing what we were doing, helping these people, making a difference. I was a nurse and not someone aspiring to be a nurse.

Including students in the decision-making process on course content, clinical expectations, and evaluation requirements provided them with a sense of control over their learning experience. Synthesis of information occurred primarily because of the in-depth nature of the experience. Reflecting on her previous academic experience, a student wrote, "This is the most important course I have ever taken."

Objectives for the course remained the same in this experience as in the traditional course, but, certainly, learning community health concepts reached new frontiers. This experience created a highly motivated student who felt a strong commitment to nursing practice.

So, while students learned from the migrant workers and their families about how to manage under great difficulties, the students also generated enthusiasm for healthcare among this community. For the community, a belief was fostered that the health system may work in their best interest. High-quality care was provided at minimal cost. For the student, a recognition was gained that with appropriate resources, nurses can make a profound change in the lives of individuals, families, and communities. Students and faculty members learned that although economic, social, and racial issues may separate communities, the basic elements of wanting a better environment and enhancing personal self-worth transcend all differences.

When asked what was most difficult about this clinical experience, a student replied simply, "Ending it."

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