Monograph series

Migrant Health Issues

Outreach Services

by

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Monograph no. 5

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Over 100 migrant health centers, along with a dozen migrant "voucher" and other special programs, are subsidized by federal funds designated to provide services to the migrant and seasonal farmworker (MSFW) community. Many of the over 800 federally qualified community health centers and rural health clinics also serve MSFWs without receiving specific migrant health funding. Since 1999 the federal Migrant Health Program has been able to boost its grant support to those migrant health centers which meet certain standards and to substantially increase funding of outreach programs. All of these efforts are salutary and, over time, should result in significant differences in MSFWs' access to primary medical and dental care and necessary ancillary services, along with improvements in health status and reduced disparities.

However, it is sobering to note that according to the most recent estimates (1990 and 1996), federally assisted migrant health services reach only about 15-20% of the nation's MSFW population (Duggar, 1990; National Migrant Resource Program [NMRP], 1996). Indeed, changing demographics in the 1990s suggest that it may be more challenging now than at any time since the inception of the Migrant Health Program to reach and effectively serve farmworkers and their families. For example, over one in three of U.S. farmworkers today are newcomers to the U.S. and a third of those are new to agricultural labor — an enormous change over less than a generation, reflecting the rapid domination of new immigrants in this workforce. The vast majority of them are monolingual in Spanish and have a median educational level of 6th grade (20% with fewer than three years of schooling). Estimated literacy is such that 85% would have difficulty obtaining information from printed materials in any language. A growing percentage of MSFWs are ineligible for public insurance, in part due to federal laws enacted in the mid-1990s (Department of Labor, 2000). Farmworkers are migrating to new areas (Home, 2000), including many communities which lack the infrastructure to provide them with appropriate health care. Finally, the undocumented immigration status of over half of today's U.S. farmworkers is likely to correlate with underutilization of medical services (Schur, et al., 1999). Federal investments need to increase and to support outreach efforts intensively. Many health disparities have been observed between MSFWs and other populations, including infant mortality, life expectancy, incidence of malnutrition and rates of parasitic infection, dental disease and tuberculosis (NMRP, 1996). Serious environmental risks for farmworkers involve pesticide exposures and other occupational injuries. As summarized by the *Migrant and Seasonal Farmworker Health Objectives for the Year 2000*, "a firm linkage to mainstream health care and human services must be delivered with a broad awareness of the unique health needs. MSFWs require effective, migrant-specific, culturally tailored health care. In appropriate languages, basic principles of prevention must be taught in lifestyle-sensitive ways. Lay advisors, crew leaders and growers must all participate in the promotion of workplace health and safety" (NMRP, 1996).

Community outreach programs have long been the linchpin in meeting these tremendous challenges to design and provide health care appropriate for the physical, cultural, and linguistic characteristics of MSFWs' lives (Arizona Department of Health Services, n.d.). The federal Migrant Health Program defines community outreach as "community-based activities with migrant and seasonal farmworkers and their fam-

ily members which improve both their utilization of health services and the effectiveness of those health services. Community Outreach acts to increase the accessibility, acceptability, and appropriateness of available health services" (HRSA, 1992). Outreach is clearly the key to surmounting these and other frequent obstacles faced by MSFWs:

· *Poverty and lack of insurance*: Outreach programs effectively convey access and eligibility information — even enrollment in public programs and vouchers for direct services (Slesinger & Ostead, 1996) — to workers in the field.
· *Distance from care and lack of transportation*: Outreach programs — offering vans, drivers, volunteer coordination, and vouchers for public transport — facilitate physical access to care.
· *Lack of knowledge about available services*: Outreach programs bridge the gap by carrying out community-based campaigns, making use of new and old technologies and media.
· *Lack of understanding of health problems and risks*: Outreach programs provide culturally competent, peer-based education by lay health promoters (*promotores)* and other community health workers, offering trainings and presentations, screenings, home visits, and other innovative services in the field.
· *Lack of understanding of the U.S. health care system:* Outreach programs oftentimes function as "traffic controllers" in local communities by providing information to farmworkers about services not only at migrant/community health centers (M/CHCs), but also at other health delivery sites (hospital emergency rooms, health departments, etc.). This simple informational step can assist with a more optimal flow of patients to M/CHC's and share the costs of providing health care among all community stakeholders.
· *Cultural and linguistic differences with providers of care*: Outreach programs utilize peer-based staff and volunteers who interpret, translate and advocate for patients, provide popular education, educate professionals in cultural competency, and even do targeted case coordination.
· *Fear or mistrust of the health care establishment or governmental* assistance: Outreach programs, through the credibility of peer-based staffing, convey accurate information and dispel rumors in their communities.

The past ten years have witnessed the growth and success of the lay promoter (*promotora)* model in migrant health. From early beginnings in North Carolina (The Maternal and Child Health Migrant Project), Arizona (*El Comienzo Sano*), and elsewhere (Watkins and Larson, 1991; Annie E. Casey Foundation [AECF], 1998), through the development of the Midwest Migrant Health Information Office (now Migrant Health Promotion) and its Camp Health Aide program in Michigan and Texas, to numerous new projects throughout the nation, the *promotora* model has become an effective movement. Outcome studies from these projects, such as one showing dramatic improvements in diabetes self-management in patients through Oregon's *Cuidando Nuestra Salud* lay health promoter program (La Clínica del Cariño, 2000), are important indicators of the effectiveness of this approach in improving access, reducing disparities, and enhancing quality of life issues for MSFWs.

Unfortunately, during the same decade that has seen these innovations and early successes, other changes in the U.S. health care system have created financial pressures on health centers to reduce or drop non-reimbursable services, including outreach. In migrant health, such a response is untenable. Outreach is an essential element of the delivery system to a changing and increasingly needy population. It requires reliable funding and logistical support.

While M/CHCs, by and large, are the leading providers of quality, affordable, and comprehensive primary health care for farmworker families in the United States, additional leadership and support is needed to assist them. Innovative strategies and resources are required to provide a larger degree of consistency and standardization among the network of health centers nationwide, while finding an appropriate balance to customize these strategies for individual local communities.

Migrant health grantees must be held to the expectation of providing substantive outreach services to farmworkers, and they must have ongoing opportunities to receive stable funding for these activities. Cultural and linguistic competence are widely recognized as being crucial to the delivery of effective health care in general. Outreach in particular requires such competence in order to surmount the hurdles and obstacles described. All federally subsi-

dized outreach programs for MSFWs must address current realities of the farmworkers in their service areas, including language, literacy, countries and cultures of origin, demographic trends, and health risks.

The cultural competency and effectiveness of lay health outreach models targeted to the MSFW population have been amply demonstrated (Sherer, 1994; Larson, 1991; AECF, 1998; Músquiz and Wiggins, 1992; Harrison Institute for Public Law [HIPL], 1997; González, 2000; Cárdenas and Davis, 2000; Bender and Pitkin, 1987). The Harrison Institute for Public Law pointed out to prospective funders in 1997 that "projected medical cost savings of timely outreach can finance community health worker program costs," (HIPL, 1997) and also emphasized that funding must be sufficient "for projects to have a chance to fully operationalize, as well as to collect and analyze meaningful data" (HIPL, 1997).

In migrant health, the challenge of making real breakthroughs during the coming decade in improving access and reducing health disparities for MSFWs depends on investing adequately in lay health outreach. Several local communities have developed other health outreach models that are proving to be effective in the delivery of care to farmworker families. Additional support to evaluate and expand these health outreach models is necessary.

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Copies may be obtained through the following sources:

National Center for Farmworker Health, Inc., Buda TX
Phone: (512) 312-2700
http://www.ncfh.org

Migrant Health Branch, Bethesada, MD
Bureau of Primary Health Care
Phone: (301) 594-4300
http://bphc.hrsa.gov/migrant/

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