

Migrant Health Issues

*Recruitment, Retention and Training of
Bilingual / Bicultural Staff*

by

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RECRUITMENT, RETENTION AND TRAINING OF
BILINGUAL/BICULTURAL STAFF

BY

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The new millennium has brought about significant changes in the demographic make-up of the United States, where increasing diversity is seen in the nation's population in terms of race, ethnicity, national origin, and language.

In the last part of the twentieth century, major population shifts took place in the United States. The proportion of persons from what have been traditionally called minority populations – African-Americans, Native Americans, Hispanic/Latinos, and Asian-Americans – grew rapidly. Among these, Latinos are the fastest growing minority population in the United States. Demographers estimated that in the 1990's Latinos would become the country's largest ethnic/racial population, and that in the two decades between 1990 and 2010, Latinos will constitute 42% of the country's population growth (Molina and Aguirre-Molina, 1994).

Lessons from the 2000 Census

These estimates were recently confirmed by the Federal government's 2000 Census. According to the Census Bureau, a 58 percent increase in the Hispanic population occurred between 1990 and 2000, with the total current population of Hispanics at 35.3 million (USDCN, b). The largest grouping within Hispanics is persons of Mexican origin (20.6 million), followed by Puerto Ricans (3.4 million), Cubans (1.2 million), and ten million Hispanics of other origin, including Central American (USDCN, b).

These new data indicate that Hispanics are approximately 13 percent of the total U.S. population. The 2000 Census puts the African-American population at 12.9 percent of the total population, Asian at 4.5 per-

cent, American Indian and Alaska Native at 1.5 percent (USDCN).

Moreover, these striking numbers may be a great underestimate. While the U.S. Census notes 35.3 million Latinos in the U.S., or 13 percent of the total population, experts deem the number to be several million higher; many Latinos have not traditionally been counted because of undocumented ("illegal") status (Molina and Aguirre-Molina, 1994). This issue is not limited to urban areas; many of these Latino immigrants are migrant farmworkers. Latinos are a growing element in rural communities throughout the United States, along with growing Native American and Asian rural populations, presenting new needs and new challenges to many rural health delivery systems.

While the Latino population has grown, Latino health status remains consistently poor (Novello, 1991; Council on Scientific Affairs, 1991; Molina and Aguirre-Molina, 1994), constituting a significant part of the health disparities challenge. Additionally, Spanish-speaking persons' dissatisfaction with care has been documented and remains an area of needed attention (Morales, 1999). Numerous health disparities for Hispanics were noted in the proposed Hispanic Health Act of 2000, H.R. 5595 (US Congress, 2000). A recent review of Latino children's health delineates a number of areas where Hispanic children fare below average in desired health outcomes (Zambrana and Logie, 2000).

Cultural Competence and Health Care

With the country's increasing diversity comes a growing need for the delivery of health care and social services that are culturally sensitive and appropriate. This need is present in all aspects of health and social

services, including dental health, mental health, and the delivery of long-term care. To address this need, the concept of cultural competence has been developed, defined broadly as a set of skills that allows individuals or institutions to increase their appreciation of cultural differences and to act sensitively, appropriately, and respectfully towards different cultures. Implicit in the concept of cultural competence (referred to as cultural and linguistic competence by some) is the provision of services and information in the language of the individual, family, or community.

Increasingly, cultural competence is seen as an indispensable characteristic of health care professionals and the programs they deliver to communities. The U.S. Department of Health and Human Services has promoted the development of cultural competence through numerous initiatives, offering the following definition:

A set of attitudes, skills, behaviors and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups. Cultural competence also focuses its attention on population-specific issues including health-related beliefs and cultural values (the socioeconomic perspective), disease prevalence (the epidemiologic perspective), and treatment efficacy (the outcome perspective) (*Cultural Competence: A Journey*, 3).

Standards for the provision of culturally competent health care services have been drafted by the Office of Minority Health (OMH, 2000). These proposed standards outline ways in which clinical and social services need to function in order to assure appropriateness of services. At the same time, President Clinton's Executive Order Number 13166 of August 11, 2000, called for the establishment of plans in all federal agencies for how they would meet the needs of LEP, or Limited English Proficiency, populations they serve. The Department of Health and Human Services was the first to develop such a plan, issued August 30, 2000.

Cultural competence is gained through numerous mechanisms, including training, the participation of

members of the community, careful community assessment, and informed evaluation of communication methods and tools. A culturally competent program will have culturally competent staff, culturally relevant materials, and culturally appropriate methods. For example, a culturally competent program targeting Indochinese mothers for prenatal care will have staff who are culturally sensitive to the population (if not from it) who speak Laotian, Hmong, Vietnamese, or Cambodian; will be mindful of the role of cultural practices in women's lives and beliefs; and will have culturally appropriate activities for children at its events.

The 1998 Presidential Initiative to End Racial and Ethnic Disparities in Health has given rise to a critical examination of many aspects of health care delivery in the United States (Goodwin, 2000). Among these are the formal training and the racial/ethnic composition of the health care workforce (AAP, 1999b). The development of the Healthy People 2000 objectives regarding health access further articulates what is needed in the health care workforce in order to make access possible for all (Agency of Health Research and Policy, 1999).

The development of a racially, ethnically, and linguistically diverse health workforce is a crucial element in providing culturally competent health care and in the realization of health care access. Unless the health workforce is able to communicate with and serve the increasingly diverse U.S. population, barriers to access will persist (Johnston, 1998). The development of cultural competence is a necessary step in the creation of an effective health workforce that can increase access and ultimately reduce disparities (Denboba, 1998; DHHS, 1998; OMB, 2000).

Cultural Competence and Migrant Farmworker Health

Changing economic and social realities have greatly affected the face of the migrant farmworker population in the United States. Today, most farmworkers are foreign born, and many speak only Spanish, according to the National Agricultural Workers Survey (Villarejo and Baron, 1999). As many as a third of today's migrant farmworkers may be working in the U.S. with-

out legal authorization or status (Ibid.), leaving them especially vulnerable and extraordinarily cautious about interactions with public agencies and officials.

The need for migrant health care workers who speak a language other than English has never been greater. The provision of migrant health services by bilingual, bicultural health care providers is essential for the realization of health care access for migrant farmworkers.

This point has been made numerous times by the National Advisory Council on Migrant Health (NACMH, 2000) and by a recently published NIOSH report (NIOSH, 1999). Farmworker access to care will be limited if the health workforce attending them is ill-equipped linguistically, culturally, and in terms of an appreciation of what migrant farm work entails.

Gaps in Cultural Competence Regarding Farmworkers

Numerous efforts have helped to develop and refine the theory and practice of cultural competence (Voelker, 1995; Lockhart, 1997; Denboba, 1998; Johnston, 1998; DHHS, 1998; AAP, 1999a; Carillo, 1999; Flores, 2000). As mentioned, the Centers for Disease Control and Prevention Office of Minority Health are taking the lead in a process of developing national standards (OMH, 2000).

However, the features of cultural competence pertinent to migrant farmworkers are distinct and unique, and flow from the conditions of life that farmworkers face. Cultural competence regarding farmworkers includes, but is not limited to, the following areas of knowledge or skill: sensitivity to limited literacy; awareness of the scope and types of occupational exposures; awareness of the environmental conditions, including substandard housing, exposure to pesticides, and constant motor vehicle travel; appreciation for the constant moving which makes application for health benefits nearly impossible; and awareness of and sensitivity to the problems associated with undocumented status.

Because the migrant labor force is made up of many Spanish-speaking workers, it is essential that Spanish language ability be a central characteristic of the

migrant health workforce. In areas where a language other than Spanish is spoken, such as among Haitians or Indochinese farmworkers, migrant health workers must be conversant in those languages. Bilingual and/or bicultural migrant health care workers are needed to perform an array of clinical services, including mental health and oral health services. In addition, bilingual/bicultural workers are needed for outreach work, which will inform migrant farmworkers of the services available to them at migrant health clinics. Because many farmworkers are not used to the ways of the U.S. health care system and may be wary of using services because of their immigration status, the use of outreach workers in farmworker communities is extremely important. This can be especially true with health services that have built-in challenges of potential social stigma such as mental health, substance abuse, and HIV prevention services.

Recommendations for Developing and Maintaining a Culturally Competent Migrant Health Workforce

Numerous steps can be taken to improve upon the training of the current migrant health workforce and ensure that it is adequately prepared to work with farmworkers. These steps involve increasing collaboration among national agencies serving non-English-speaking people, removing barriers to obtaining health care training for non-English-speaking persons, enhancing the cultural competence of all health care providers, and developing research to better understand the migrant health workforce.

Recommended implementation strategies include:

1. *Promote linkages among and between Hispanic and other minority health agencies and initiatives.*

Many national organizations and initiatives focus on Latino/Hispanic health and on the health concerns of other minority groups such as African-Americans, Asians, Haitians, and Native Americans. These organizations and initiatives, such as Health Resources and Services Administration (HRSA)'s Hispanic Health Initiative, the Latino Caucus of the American Public Health Association, and the Society for the

Advancement of Chicanos and Native Americans in Science, are key linkages that migrant health advocates, trainers, and educators need to make. By sharing knowledge, resources, and ideas, these organizations can help to recruit, train, and retain bilingual/bicultural persons in the migrant health workforce.

2. Develop medicine, dentistry, nursing, public health, mental health, and allied health pipelines for Hispanic and other minority students.

It is essential to develop mechanisms for building awareness of health career opportunities in Hispanic and other minority communities, as well as to recruit and support Hispanic and other minority students' application and matriculation to medicine, dentistry, public health, mental health, and allied health programs. Special pipelines that target Hispanic youth are needed, beginning as early as elementary and middle school.

One such pipeline program available today is HRSA's Health Careers Opportunity Program or HCOP, which is designed to bring educationally and economically disadvantaged students into health careers, building interest as early as elementary school. The HCOP Program should be expanded to target rural Hispanic populations, with an emphasis on migrant farmworkers. A targeted program would both recruit and mentor Hispanic students in general, and make special efforts at recruiting former farmworkers and children of farmworkers from any ethnic group.

3. Student loan repayment/forgiveness programs for those who serve in the migrant health workforce.

At present, student loan forgiveness programs are available to a number of professions for service in communities where it has been historically difficult to recruit personnel. For example, physicians, police officers, teachers, and family and child agency workers are all eligible for loan forgiveness programs, making training for these careers much more financially feasible.

A loan forgiveness program for people who serve in a

migrant health clinic, or in some other capacity in the migrant health workforce, could provide loan repayment relief for a period of service. This would make it possible for a person with limited financial resources to seek professional training, which otherwise would saddle them with at least a decade of extensive student loan debt. With a loan forgiveness program in place, academic training programs in public health, nursing, dentistry, allied health and social work would have greater appeal to these individuals, and would help assure a diversified workforce in migrant health.

4. Inclusion of cultural competence training requirement in health care professional curricula.

At present the country's medical, dental, mental health, allied health, and public health schools are only beginning to require training in cultural competence. Such training is increasingly seen as essential to health provider training. By making cultural competence training a requirement in health care provider curricula, the health care workforce will be enhanced and its capacities increased. Within the required course or module, specifics of migrant farmworker health and welfare could be explored, expanding the ranks of persons prepared to work with migrant farmworkers.

5. Language training for health care providers.

Similarly, it is urged that all persons entering health care training programs be encouraged and enabled to gain additional language skills, with a particular emphasis on Spanish. Introductory courses in medical applications of Spanish should be available in allied health, dentistry, medical, nursing and public health schools.

6. *Research on the migrant health workforce.*

Not enough is known about the training needs of the current migrant health workforce. Research needs to be conducted that examines numerous areas, including:

- Current training regarding migrant health available in health professional schools,
- Gaps in cultural competence in current migrant health staff,
- Employment performance standards for migrant health employees, and
- Mechanisms and models needed for inclusion of former migrants in the health care workforce.

Conclusion

There are numerous steps that can and must be taken to meet the current challenge of developing a bilingual/bicultural migrant health workforce that can provide culturally competent care to farmworkers. Embarking on these steps will ensure that the migrant health workforce required to adequately address farmworker health needs will be developed, enhanced, and retained.

Produced for the National Advisory Council on Migrant Health by the National Center For Farmworker Health, Inc., Buda, TX, October 2001.

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, Bethesda, MD
Bureau of Primary Health Care
Phone: (301) 594-4300
<http://bphc.hrsa.gov/migrant/>*

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