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A Smoother Road for Migrants

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Years of studying the plight of our perhaps most-neglected minority group—migrant workers—are culminating at last in action to furnish medical and nursing care, and health education at migrant family service clinics dotted across the national map. Sponsored by community groups, these projects are supported jointly by the U.S. Public Health Service, under the Migrant Health Act, and by local permanent residents who are interested in the health of their temporary neighbors, the migratory farm employees.

Placing a man on the moon is a goal that we as a nation approach with confidence. But to provide continuous medical services for migrant people as they move from one work area to another is a task that still confounds us!

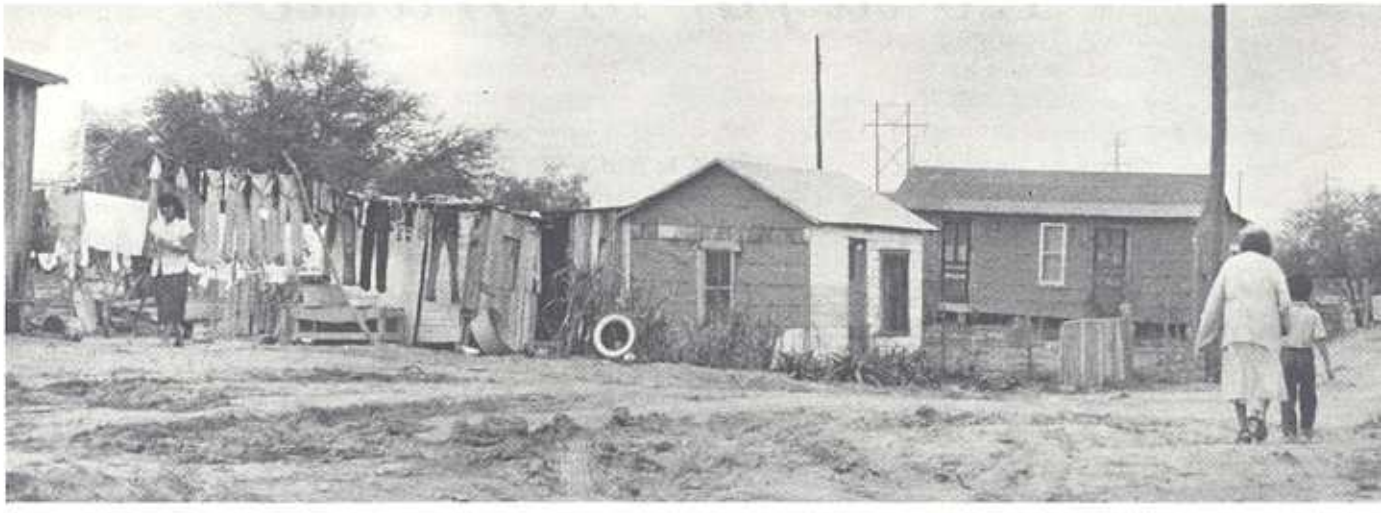
The accusation, "When you can't resolve a problem, you conduct a study!" has some validity in the migrant labor field as reports of national, state, and local commissions accumulate on dusty shelves.

From the report of the Country Life Commission in 1909 to the latest findings, the recommendations are monotonously alike: improve housing, license and supervise camps, guide workers, raise family income, provide adult and child educational opportunities, extend health and medical services, establish day care for children, and so on.

Yet the million U.S. migrants who move seasonally for agriculture work still exist under substandard conditions. They continue to have long idle periods when no work is available. And they continue to have difficulty in gaining access to community services—meager in some work communities, or offered at points far from migrant locations, and often restricted to local residents. That so little has been done to implement sound recommendations may reflect the intrinsic difficulties involved.

The greatest obstacle is that solutions to problems cannot be achieved in any single place. The migratory farm laborers, some two to three million men, women, and children from various socioeconomic minorities, live during the winter in the southeast and southwest. The agricultural areas to which one third of this population travels during a given year are scattered widely over the whole United States. Altogether, nearly 1,000 counties in 48 states are encompassed by the three major streams of migration: one along the east coast, one along the west coast, and the third fanning out from Texas to all the central states. Therefore, plans developed in south Texas for Spanish-speaking migrants must be fitted in with solutions in such northern states as Michigan, Wisconsin, the Dakotas, Montana, Washington, and Oregon. Migrant programs in Florida for southern Negro workers must be coordinated with those in Virginia, Pennsylvania, New York, and other states.

For example, one 12-year-old boy who had poliomyelitis at eight months, was seen last summer in a Pacific Northwest county. During the previous five years, he had been examined and had his braces repaired in California, Texas, Louisiana, Idaho, and Oregon. His 1965 examination indicated the necessity for corrective surgery. An application



NURSES working in migrant health projects find themselves practicing in a variety of settings. Those shown above are in Wisconsin (top left) and Kansas (top right). Long-term reforms must be tied in with solutions to such problems as housing and sanitation.

was made to a private charitable institution. His family waited until late fall for his appointment—only to be told to come back in six months *if* they returned to the same work area!

Often more than one family member has a serious health problem. For instance, all but 1 person in a family of 13 had positive tuberculosis test reactions. Although the father had been ill most of the summer, he would accept neither testing nor an x-ray, but his nine children were x-rayed. For four of them, the physician recommended prophylactic Isoniazid for two years. However, because this family left the area within three days, local nurses only could send a detailed report to the state where the family reportedly spent the winter in the hope that they could be found and treated there.

Long-term, practical reforms in health care must be fitted into solutions of such problems as housing, sanitation, employment, low family income, community-migrant relationships, and education. Programs which aid one migrant group may not help others, at least not without modification to suit their inherent differences. Language variations among migrant groups are obvious, but health workers must recognize the more subtle distinctions among people and groups if they are to serve migrants effectively. For example, a high-school educated migrant who is potentially a helpful ally is quickly alienated if an approach to him is based on the false stereotype that all migrant workers must be illiterate.

Critical to gaining acceptance of medical services by migrants are the professional workers' understanding of migrants and the readiness of health personnel to shape their attitudes, their services, and the settings where these are offered to the people and their situations. Too often in the past, migrants have been called "uncooperative" because they failed to adopt local health patterns—patterns which might vary in each work community. Confused, migrants may justifiably have looked upon health workers as hard to understand or reach.

Not the least of the past difficulties has been lack of funds. Typically, those communities interested in assisting migratory families lacked the necessary nurses, sanitarians, and health educators, and had no money to employ more staff.

With the 1962 passage of the Migrant Health Act, things took a heart-

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GENERAL MEDICAL CARE to families is provided by nearly two-thirds of the migrant health projects. Although statistics are difficult to collect, project workers report more mothers seeking care in early pregnancy and fewer children with acute diarrhea.

ening turn. The Act authorized grants by the U.S. Public Health Service to either public or private nonprofit groups for part of the cost of family service clinics or other activities to improve migrants' health services and conditions. The original, three-year authorization was an experimental measure to assist community-sponsored migrant projects, and in this process to delineate more precisely the extent of migrants' health needs. Once a realistic community service was established, migrants themselves could be encouraged to apply good health and safety practices.

Congressional reports at the time of the 1962 Act specifically enjoined against the payment of hospital bills on the premise that some hospitalization could be eliminated if migrants had early medical care, sanitation services to improve their living and working environment, and education to enable them to maintain good health. In 1962 Congress regarded an emphasis on prevention as more important than paying hospital bills.

By April 1966, 78 projects had obtained migrant health grants which paid about 60 percent of total project costs. The remainder is met by the applicant from other sources.

Some projects serve migrant farm workers and families in a single county or part of a county; others cover up to 15 or more counties. Most projects operate seasonally, with a dormant period in winter and renewed activity in the spring. Only projects in the so-called "home-base" areas, where migrants live during the off season and work if work is available, operate the year around. These homebase programs serve the reservoir population from which migrants are drawn, since no one knows who will move the following spring or which family member may join others in the north during the summer even though he had planned to stay in the south. Many projects began with limited services, or within a circumscribed geographic area but with plans to expand as they learned how to proceed successfully. Most have added more services, or modified their programs in other ways as they entered the second or third year of operation.

Sanitation, nursing, and health education—in that order of importance—are the services common to all migrant health projects. Otherwise the projects vary from area to area. Nearly two thirds provide general medical care to families, usually at night two or three times a week, at or near points of large migrant population. Ordinarily clinics are held in abandoned schoolhouses, church basements, or housing units in labor camps. A few projects transport mobile equipment from place to place during each week. The clinics usually are staffed by community physicians who are paid an hourly or

session fee based on the rate for public health clinic services, or on the local welfare rate.

In lieu of extending generalized family health services, some projects refer migrants to area physicians and reimburse them at the fee for welfare cases. A public health nurse visits the migrant to determine whether he saw the doctor; whether he is following the doctor's instructions, and, if the referral was not completed, the nurse tries to learn why and eliminate any obstacles that stand in the way. Where physicians, nurses, clerks, receptionists, and others donate their services to a project, this is calculated as part of the local contribution. Dental needs of migrants have come very early to the attention of project staff. Other services include medical social work and nutrition.

Public health agencies have led in the development of most community projects. Occasionally, the applicant is a local migrant committee, a board of supervisors, or some other interested group qualified to operate a health program. Project directors include physicians, ministers, a scientist, a hardware dealer, a school principal—many different community leaders who have won the support of local professional health workers essential in project operation.

Allies to project operation have sprung up regardless of the projects' auspices: local agricultural extension agents help to find migrant camps and participate in adult education programs; church groups transport patients to clinics or other agencies; day care centers and summer schools for migrant children refer sick youngsters and teach good health practices; the Lions Club often buys glasses for migrants; and the public employment service not only determines where migrants are, their numbers, and how long they will stay in an area, but it also informs migrants and growers about the project.

With the annual turnover in migrant "census," and the seasonal turnover in every project area, the usual measurements of health and services—morbidity and mortality statistics—are extremely hard to come by. However, project staffs report seeing fewer children with the acute diarrhea that requires hospitalization, and more mothers seeking care early in pregnancy. They also note a growing acceptance of services by migrants and increasing community participation as cited in these excerpts from annual project reports:

Among crewleaders [the persons responsible for recruiting and finding jobs for migrant workers, especially on the East Coast], some showed "a surprising responsibility and concern for members of their crews." We got good cooperation . . . in regard to transporting patients to clinics and in referring sick persons to our staff. . . .

Although one grower objected to having his workers approached . . . , most were very cooperative and stated that they were glad more efforts were being made to provide facilities and services for migrant workers. One grower's wife paid for braces for a migrant child when the need was brought to her attention. . . . Another grower paid a hospital bill for a child with diarrhea. . . .

As physicians saw the needs of the migrants, they gave much more freely of their time, professional services, and even supplies. Nurses who had been unfamiliar with the migrant situation became champions for promoting better health measures and seeing that the migrant workers found medical care. (Some of these nurses had been inactive, had had no previous public health preparation or experience, and had been recruited for short-term project employment.)

There is a feeling in the community that such a program has many advantages, not only in the health area but social as well. All personnel . . . found the migrant families easy to work with and cooperative.

Some projects still report frustrations: the limited time in which care must be given; the nonattendance of migrants at family health clinics which are far from their camps; overcrowding of project clinics with consequent lack of privacy or time with patients; inability to find the extremely mobile migrant to determine the outcome of his referral, or to carry out a referral from another project area; the lack of receptivity of those migrants who need assistance most.

With regard to difficulties in obtaining hospitalization for patients, a national evaluation team working under the American Public Health Association commented that exclusion of the migrant and his family from hospital care was the most frequently and universally mentioned deficiency in the program and the principal deterrent to adequate care.

When the Migrant Health Act came before Congress for renewal early in 1965, it was extended for three years, the prohibition against use of grant funds for payment of hospital bills was removed, and the appropriation ceiling was raised. Hospitalization is limited to 30 days for any one admission and applies only to care in general short-term agencies. It permits such payment to hospitals only by approved projects which offer general medical care through family clinics or other arrangements geared to migrants' work and life situations.

Project applicants for hospital care monies must furnish evidence of migrants' need for hospitalization, and of hardship to hospitals if reimbursement is not made. Applicants also must establish agreements with hospitals to serve migrants at pre-established rates based on reasonable costs.

The migrant's road is still rough, but his chances of finding health services along the way are improving. And communication among health workers serving the migrant in his journey grows easier as the United States map becomes dotted with projects trying hard to serve him and his family. △