

streamline

The Migrant Health News Source

MCN Health Network, Improving Continuity of Care

Clinicians serving mobile populations face a number of challenges to providing high quality care and follow-up. Among the most difficult issues to address are high rates of no-shows and patients who are lost to follow-up as well as limited availability of a complete medical history for mobile patients.

For the last eight years MCN has worked to address the unique challenges of mobility through a tracking and referral system that provides patient follow-up and continuity of care for mobile populations. MCN believes that mobility should not be a barrier to access and continuity of care.

By the mid-1990s, many clinicians and public health officials recognized the need for a way to track and coordinate the treatment of TB patients who moved between public health jurisdictions. In 1996, the Migrant Clinician's Network, working with a consortium of public health organizations, and funded by a grant from the Texas Department of Health, founded TBNet to address this problem. Although the program was originally created with migrant farm workers in mind, it has expanded its patient base to include the homeless, immigration detainees, prison parolees, or anyone who might be mobile during their treatment.

Since 1996, TBNet has worked with over 1,700 participants within the United States and those who have moved abroad - from the Texas/Mexico border all the way around the world to China. TBNet has proved that tracking migrant patients can be successful.

Following this initiative, MCN created a new program to track and provide care coordination services to mobile patients with diabetes. This program is called Diabetes Track II. This program allows clinicians to meet the minimum standards of care in face of the steadily rising rates of diabetes in the United States. Providers participating in this program can now know if their patients

have received annual tests (such as a dilated eye exam) at another site within the past 12 months. Track II gives these providers access to their patients' complete medical histories. Track II also provides patient education (by phone and mail) on prevention of diabetes and its complications.

In 2004, through a cooperative agreement between HRSA and CDC, MCN initiated a new tracking program for patients that have been screened or need screening for breast, cervical or colon cancer. The new program is called CAN-track. CAN-track was created in response to the challenges clinicians face when trying to report screening results to patients that have moved to another town in search of work. It allows clinicians to make sure that their patient gets re-screening or further diagnostic tests if the results of the initial screening are abnormal. It also eliminates the need for re-screening due to an absence of any records concerning cancer-screening history.

MCN has assembled all three tracking programs, TBNet, Track II and CAN-track, under one umbrella called the **MCN Health Network**. This will allow clinics to participate in all three tracking programs by using standard forms and one time training. The **MCN Health Network** has developed a interactive Training CD in all three programs that allows clinics to download patient consent forms, HIPPA agreements and other material necessary to participate in any of the three programs. The Training CD will also allow clinics to train several providers at the same time and can be used as a resource for new providers. There is no cost for the Training CD and MCN staff will provide Technical Assistance to help providers design an effective implementation of the programs in their clinic.

The **MCN Health Network** also provides patients with one single identification card for all three programs. The card, which looks



like a credit card, has a unique identifying number and a signature panel to write the patients name. The unique identifying number allows MCN staff to know where the card originated and to whom it belongs. To use the card the patient must choose a PIN number, which will allow providers prompt access to the patients' medical records. And in the future will allow for electronic transmission of the records. The patient should present this card at all clinic visits.

To help patients understand how MCN Health Network can assist them and to help them take advantage of this service, MCN has designed a tri-fold pamphlet with appropriate messages and information. It stresses the importance of showing the card at all clinic encounters and the benefits of doing so. The tri-fold has an insert that helps the participant choose a PIN number and helps him/her understand the importance of keeping this number. Both, the tri-fold and insert have been pilot tested and have been developed with input from migrant workers.

MCN Health Network services and resources are available at no charge; you may request resources, technical assistance or schedule a free training at any time by calling 512-327-2017 or e-mailing Andrea Kauffold. ■

Hispanic Immigrants on the Eastern Shore of Maryland

Tim Dunn, PhD, Amy K. Liebman, MPA, MA

Editor's Note: The following article is excerpted from a needs assessment report that was conducted among recent immigrants on the Eastern Shore of Maryland. The assessment was funded by the Eastern Shore Regional Library in partnership with a network of service providers, including clinicians, who are struggling to meet the needs of the area's rapidly growing immigrant population. The report offers Streamline readers both a snap shot of the changing face of migration and a useful methodological approach for gathering data among migrant populations. A full copy of this report is available at <http://beacon.salisbury.edu/bien/welcome.htm>

Migration is dramatically changing the demographics of the Maryland's Eastern Shore. According to Census 2000 from 1990 to 2000, the Hispanic population on the Eastern Shore increased at unprecedented rates — as high as 136 percent and in some counties over 200 percent. This trend is projected to continue. In contrast to previous decades, most of the Hispanic immigrants in this region are now settling here year round rather than just staying temporarily as migrant farmworkers. Consequently, the Maryland's relatively isolated and rural Eastern Shore is experiencing the most significant influx of settler-immigrants of one broad type (Hispanic) since the colonial and slavery eras. The shift in migratory patterns from seasonal and migrant workers to settler-residents represents new challenges to both the immigrants and local communities.

Methodology

The needs assessment included an ethno-survey (combining ethnographic interview style with survey research data collection and recording) administered to 185 Hispanic immigrants living in four Eastern Shore counties of Maryland; eight focus groups with 90 Hispanic immigrants and three focus groups with 35 service providers.

The methodological approach of the ethno-survey was developed over the past twenty years by the Mexican Migration Project, which has interviewed thousands of immigrant households in Mexico and the United States. (Massey, 1987; Massey et al., 2002). In an ethno-survey, interviewers use a semi-structured interview technique based on a list of topics, sub-topics, and some suggested question wording, but use their own judgment for question wording and timing as appropriate for the situation, allowing the

respondents to answer in their own words. Rigidly structured questions and closed-answer questions typically used in survey research are often culturally inappropriate, impractical, and too obtrusive in researching Mexican immigrants, most of who have low educational levels and little to no previous contact with survey research. Thus, the ethno-survey combines less obtrusive nature of ethnographic interviewing with the topic and data standardization of survey research, making for an informal, less threatening, and more natural interview that at the same time produces a standardized set of data.

The ethno-survey was administered by the project directors along with a well trained team of six bilingual interviewers with extensive contact with local Hispanic immigrants. A random sample to choose respondents was not possible in this case of this study. Instead, the project used snowball sampling or network referral sampling techniques (Neuman, 2003:214), in which respondents are recruited by obtaining referrals to potential respondents from those you have already interviewed. This technique is also used in the United States portion of the Mexican Migration Project research, as it is too costly and impractical to use a random sample in migrant-receiving communities in the United States (Massey et. al., 2002). Each of the respondents received a bilingual pictorial with over 100 pages of colorful drawings as an incentive to participate (Parnwell, 1989). This incentive was one of the key factors in the project's successful recruitment of participants.

Results

In general the region's Hispanic immigrants are:

1. primarily mono-lingual Spanish speakers from rural areas of Mexico and Guatemala with a limited formal education;
2. predominantly male, but include a significant minority of females;
3. young, inexperienced migrants who are new to both the Eastern Shore and the United States and unauthorized or illegally here;
4. a rapidly growing population who intend to stay in this region;
5. very isolated from the receiving communities with few social ties outside of the immigrant community;
6. living in crowded households with family and friends, mainly adult males.
7. vulnerable and disproportionately victims of crime relative to general population;

8. employed full-time for low-wages in largely hazardous occupations such as construction and agriculture and taxes are withheld for the vast majority; and
9. sending money to their families in their home country and saving approximately \$500 per month.

Those surveyed feel LANGUAGE is by far the most difficult aspect of life in the region, followed by transportation, lack of documentation, low-pay and other work-related problems. Just down the list in fifth was crime followed by lack of health insurance and housing. ENGLISH CLASSES and access to TRANSPORTATION services (including drivers' licenses) are the two primary services desired by those surveyed.

Education and Language

On the whole, the education level of our respondents is low by US standards and their understanding and usage of English is quite limited. The median educational level of the respondents is 6 years, or completion of primary school — about average for the sending countries of the respondents. Until recently, public education was free only through primary school in Mexico. Above that, approximately one-quarter fell in the "middle school" category (7-9 years of education) and just 16.8% has more than nine years of education. On the other end of the continuum, nearly one-quarter of the respondents had three years or less, including some 8% who had zero years. As for their educational experience here, few respondents have attended school in the United States or taken a class of any type here, though nearly all those that had had taken an English class.

There was a noticeable difference in median level of education when comparing respondents by country of origin, but not by gender. There was no difference in median years of education between males and females (it was six years for both). However, the median years of education for Mexican respondents was six years, while it was four years for Guatemalans — the two main country-of-origin groups among our respondents. This is not surprising given that Guatemala is a much poorer country than Mexico and its education system is less extensive.

Language was a key issue for our respondents. Language problems were the number one ranked difficulty here for our respondents, and English classes was their most

desired service. Some 96% said Spanish was their main language, though some 10% said they spoke an indigenous language (eight dialects).

Information Sources

For information the respondents most strongly rely on national Spanish language television stations (namely Univision) as well as family and friends (who are themselves also immigrants). The latter two sources confirm the impression of many who work with Hispanic immigrants that word-of-mouth within the local immigrant community is the primary mode of communication. This is not unusual given the language barrier, as well as respondents' generally low education level, relatively recent arrival here, lack of out-group social relations and the importance of immigrant social networks.

Social Service Contact

In general, Hispanic immigrants on the Eastern Shore appear to be fairly socially isolated from the receiving communities in terms of contact with local social service providers and social relations with other groups. There are only two institutions (apart from places of employment) with which a majority of respondents have had contact: health services and religious bodies. Also striking in the findings is the significant minority who lack of trust in police services accompanied by a relatively high level of crime victimization, as well as low levels of involvement in social groups and non-immigrant social relations.

The respondents and their households have had little contact with educational institutions. Only 15.7% of the respondents reported that they had attended school here, while just 26.5% said they had taken some sort of class here, with English being the overwhelming type of class (85.7%), typically provided by or hosted by churches, libraries, and college professors.

In contrast, respondents reported quite significant usage of health services, as some 60.5% said they or a family member had received medical attention here, and the majority (57.5%) reported they had used health services just a few times. Hospitals are the most frequently used care provider (49.5%), followed by clinics (39.8%), and lastly private doctors (10.7%).

The focus groups add additional data to understand the limited contact with the health care system and use of the hospital. First, the adult immigrant population is not necessarily likely to seek primary health care services. Contact with the health care system occurs when the health situation is more severe. As one focus group participant noted:

"We're a bit stubborn when it comes to

health. If I come down with the flu, I know that it'll eventually pass. I'll call into work and tell them that I'm sick, but I won't go to the clinic. As long as we don't have any broken bones, we won't go to the clinic."

Second, many immigrants are accustomed to self-treatment or home remedies. In Mexico and Central America medication is readily available at pharmacies and a prescription is not required. Several focus group participants noted that over-the-counter medications "is the only way to get better"



and mentioned their previous experience using antibiotics (which are available without a prescription in the sending countries). "In the past, I've been in bed for three days and I couldn't work because I had such a high fever—the antibiotics worked."

Lastly, language is a perceived barrier to seeking health care services. As one focus group participant noted: "How can we try to get medical attention when we can't even speak English?" Several upper shore focus group participants mentioned driving to Pennsylvania (about one hour) to go to a Spanish-speaking doctor who helps Hispanic immigrants with their medical needs. They noted this physician charges on only thirty dollars, including medication. Other focus group participants noted positive experiences, particularly for prenatal care.

Migration History and Future Plans

In general, the respondents are newly arrived, inexperienced migrants and still-forming social networks here. The overwhelmingly majority entered the county illegally and have been unable to return home. Interestingly, a majority expects to remain here for the medium-term future. Many of these points merit some elaboration. Before proceeding, however, it is important to reiterate that our respondents were almost entirely from Mexico and Guatemala, and that the strong presence of Mexicans in

our findings is consistent with the shift in the geography of Mexican migration noted during the 1990s away from traditional receiving areas such as California, and into a host of non-traditional receiving areas begun including the south, mid-west, and parts of the east (see Durand, et al., 2000).

It is also important to note the newness of both ends of the migration process. Not only is Delmarva a new immigrant-receiving area immigrants, a significant minority of the Mexican respondents also come from states that do not have a history of sending migrants to the United States in large numbers (notably Vera Cruz and Chiapas), though the Mexican respondents come from a diverse range of 21 states overall. In addition, the individual respondents themselves are as a group quite inexperienced, with some three-fourths having made only one trip to the United States and nearly 60% listing Delmarva as their first migration experience

The social networks of Hispanic migrants on the Eastern Shore appear to still be in the early stages of formation, not only because of the respondents recent arrival, but also because a majority of respondents said they had few family or friends here before they arrived. On the whole, our respondents appear to be among the pioneers for migrant social networks in the area. This is crucial because it suggests that the region is in the early phases of a larger migration process in the region, because once migrant social networks become well established between receiving and sending communities, migration tends to become self-perpetuating (Massey, et al. 2002: 20).

Not surprisingly, economic factors dominated among the responses as to why people said they came to the United States and to Delmarva specifically: to work, save money, and have a better life, cumulatively, accounting from nearly 80% to over 90% of the responses for questions about each destination. In contrast, reunifying with friends and or family accounted for between 5-15% of the responses.

Looking at travel and future plans, it seems that the majority are likely to remain on Delmarva. The vast majority has not yet made a return trip, mainly due to lack of immigration documents, lack of money, and recentness of arrival – which suggests little circular migration on the whole. As for the future, a majority (57%) indicated they planned to be living in the same town on Delmarva in three years, while 42% said they plan to move back to their country of origin in three years. This has strong implications for the receiving communities, as they will need to respond to Hispanic immigrants

continued on page 4

that are here to stay through the medium term. Moreover, the numbers on immigrants on the Eastern Shore are likely to grow because the rate of immigration seems to have accelerated when comparing the 2000 census data with the recentness of arrival of our respondents and because immigrant social networks are still in formation; when they are well established they tend to make migration self-perpetuating.

Work

Work is the overwhelming reason most of the respondents came to the Delmarva. Some 95% of the male respondents were currently working at the time of the survey, as were 64.5% of the female respondents, for a total rate including both sexes of 84.7% (with 15.3% being unemployed at the time). To put this in comparative perspective, the labor force participation rates for both sexes together in the United States is 63.9%, and for US males and females is 70.7% and 57.5%, respectively. Even in the most active, peak work years category of 25-54 years old, the US male and female rates are 81% and 70.1%, respectively (US Census Bureau 2002).¹

The survey included questions about work in four different ways – i.e., asking for their current job, more recent job (includes that of those currently unemployed), second most recent job, and third most recent job. The four main occupational sectors are remarkably consistent across all four job type questions: Construction and Landscaping, Agriculture, Services (restaurant, hotel, domestic, and maintenance), and the Poultry Industry. The order of the first three broad categories varies, depending on how far back one goes in the work history, but Construction and Landscaping are the leading one for the current and most recent occupation questions, those with the highest number of responses, suggesting a shift toward that occupational category more recently. Also notable is the fact that agriculture accounts for 43.2% of the respondents’ third most recent job while only 18% of the respondents’ current jobs. This suggests that agriculture may be a job that immigrants have when they first arrive and that they may move to other jobs as they spend more time in the United States.

¹ Labor force participation is defined broadly by the US Census Bureau to include those 16 years old and above who are not only employed, but also those who are unemployed but seeking work as well as members of the military. Thus, the comparison with our survey data is probably understated, because we refer only to currently employed respondents.

**Table 1:
Current Occupation in the United States/Delmarva**

Occupation	Number	Percent
Construction & Landscaping	49	26.8
Agriculture	33	18.0
Services (Restaurant, Hotel, Domestic, Maintenance)	33	18.0
Poultry	16	8.7
Unemployed**	28	15.3
Other	25	13.7
Total	183	100.0

** Some 80% of the unemployed are females, and of those unemployed females, 91% have children here (i.e., they are likely engaged mainly in childcare and household labor).

Conclusion

Though their overall numbers are still small, the rapid growth of the Hispanic immigrant population is already shifting the demographic landscape on Delmarva and will likely even more so in the future. The immigrant social networks here are still in formation and most have only arrived recently, but once they become more established, the migration process to Delmarva will likely accelerate and include more females and children. This is especially likely to be the case if the local economy continues to grow

and as the native population ages and their labor force participation rates drop. In addition, as the Hispanic immigrant population grows and becomes more well established, we should expect to see their emergence as active community social actors and advocates on their own behalf, particularly if immigration policy changes to allow a regularization of the status of those who are currently unauthorized. In order for the receiving communities as well as immigrants to make this transition successfully, mutual collaboration and preparation is necessary. ■

REFERENCES

Allen, Mike. 2004 (Jan. 8) "Bush Proposes Legal Status for Immigrant Labor." *Washington Post*.
 Associated Press. 2003 (Aug 29) "Money Sent Home by Mexican Migrants Tops Foreign Investment and Tourism" *New York Times*.
 Becker, Elizabeth. 2004 (May 18) "Latin Migrants to U.S. Send Billions Home." *New York Times*.
 Dunn, Tim J., Ana Maria Aragones, and George Shivers. (forthcoming) "Recent Mexican Migration to the Rural Del-Mar-Va Peninsula: Human Rights vs. Citizenship Rights in a Local Context" in *New Destinations of Mexican Immigration in the United States: Community Formation, Local Responses and Inter-Group Relations*. Víctor Zúñiga and Rubén Hernández-León, editors. New York: Russell Sage Foundation.
 Durand, Jorge, Douglas S. Massey, and Fernando Charvet. 2000 "The Changing Geography of Mexican Immigration to the United States: 1910-1996." *Social Science Quarterly*, vol. 81, no. 1, pp.1-15.
 Eastern Shore Regional Library. 2003 "LSTA Grant Application for Project Adelante."
 Honawar, Vaishali. 2004 (May 12) "Ehrlich won't retract remarks." *The Capital*. (Annapolis, Md.)
 Huntington, Samuel P. 2004 (March-April) "The Hispanic Challenge" *Foreign Policy*.
 Inter-American Development Bank. Sending Money Home: The first State-by-State Analysis of US Remittances to Latin America, 2004" Web Site: <http://www.iadb.org/exr/remittances/index.cfm>
 Massey, Douglas S. 1987 "The Ethnosurvey in Theory and Practice." *International Migration Review*, vol. 21, no. 4, pp. 1498-1522.
 Massey, Douglas S., Jorge Durrand, and Nolan J. Malone . 2002 *Beyond Smoke and Mirrors: Mexican Immigration in an Era of Economic Integration*. New York: Russell Sage Foundation.
 Neuman, W. Lawrence. 2003 *Social Research Methods: Qualitative and Quantitative Approaches*. Boston: Allyn and Bacon. 5th edition.
 O'Brien, Robert M. 2000 "Crime Facts: Victim and Offender Data." in *Criminology: A Contemporary Handbook*. Joseph Shelley (editor). Belmont, CA: Wadsworth. Pp. 59-84.
 Portes, Alejandro and Ruben G. Rumbaut. 1996 *Immigrant America: A Portrait*. Berkeley: University of California Press. 2nd edition.
 Parnwell, E. C. 1989 *The New Oxford Picture Dictionary: English/Spanish*. New York: Oxford University Press.
 Sheridan, Mary Beth. 2001 (April 15) "Illegals Paying Millions in Taxes; Most Don't Seek Refunds For Fear of INS Action." *Washington Post*.
 Sjoberg, Gideon and Roger Nett. 1997 (1968) *A Methodology for Social Research: With a New Introductory Essay*. Prospect Heights, IL: Waveland Press.
 US Census Bureau. 2002. "Table QT-P24," *Census of Population and Housing 2000*. Website: <http://factfinder.census.gov>

Injury and Illness Patterns of Migrant and Seasonal Crop Harvesters

Julie Sorensen, MA

Occupational health can be one of the most prevalent patient care issues for clinicians working with migrant and seasonal farmworkers. Farmworker patients are a unique segment of the US workforce and factors such as lack of training, language barriers, piece-rate pay, illegal worker status, and geographical and cultural isolation can put these workers at increased risk for work-related injuries and illnesses. Many of these factors also make it difficult to assess injury rates and patterns in this population. Work-related injuries and illnesses often go unreported because access to healthcare and workers compensation insurance require a knowledge of these systems, transportation, a permanent address and an ability to read and speak English.

However, some attempts have been made to characterize farmworker occupational health patterns in different regions of the United States and these inquiries have led to a variety of injury rates. Researchers investigating occupational injuries and illnesses in South Carolina (McDermott and Lee, 1990), North Carolina (Ciesielski et al., 1991), Ohio (Isaacs and Bean, 1995) and California (Villarejo, 1998) have found rates anywhere from 5.2 to 11 percent. There are currently no published rates for the Northeast.

In an effort to learn more about migrant and seasonal farmworker occupational injury and illness patterns in the Northeast, the New York Center for Agricultural Medicine and Health, has recently completed a surveillance project involving migrant health center chart audits at 12 federally-funded migrant health centers in seven states in the Northeast (ME, CT, MA, NY, NJ, PA, MD) (see Figure 1). This source of occupational health data seemed most appropriate since health center data would include information on injury event, contributing factors and diagnosis. In addition, it seemed likely that health centers would treat the majority of farmworker occupational injuries since they are based in heavily populated farmworker regions and offer farmworkers reduced health care service fees, interpretation and culturally appropriate health care.

In addition to health centers, Emergency Rooms were recruited in one region of the Northeast to assess the degree to which this healthcare source is utilized and to establish whether the occupational injury patterns at this source of health care differ vastly from

Figure 1
Participating Federally-Funded Migrant Health Centers and Voucher Programs



migrant health center injury patterns.

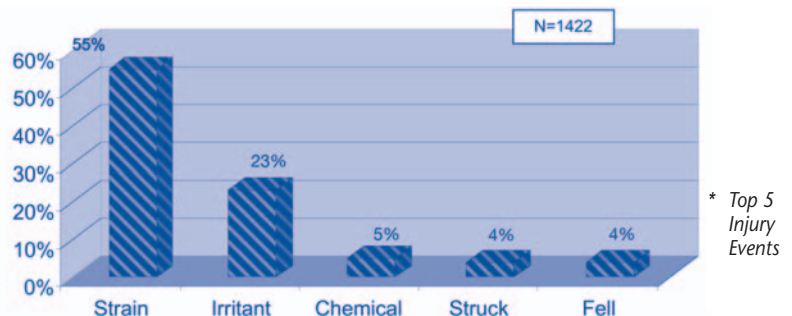
Over the course of two years, 1,690 migrant and seasonal farmworker occupational injuries and illnesses were documented at Migrant Health Centers and Emergency Rooms throughout the Northeast. Migrant and seasonal farmworkers were defined as workers involved in the hand harvesting of crops that are not employed year round. 1,422 of these injuries and illnesses were treated at Migrant Health Centers in each of the seven states previously listed and 268 were treated at Emergency Rooms in one region of New York State and various other hospitals spread throughout the Northeast.

The majority of injuries and illnesses presenting at Migrant Health Centers involved musculoskeletal sprains and strains (55%) (See Figure 2). This is not surprising when

considering the conditions surrounding crop harvesting. Often workers spend long hours in awkward postures with few breaks because of pressure to harvest crops while they are still marketable. Indeed, many of the sprains and strains documented, indicated bending or stooping (27%), lifting (21%) and carrying an object (10%) as the main contributing factors to the injury (See Figure 3).

Exposure to natural irritants was also a frequent injury event amongst farmworkers (23%). Natural irritant refers to substances such as plant materials, sun, water, or dust that can cause skin or eye irritations. Dermatitis and allergic reactions were frequently diagnosed in farmworkers exposed to these irritations and working conditions frequently contributing to these exposures included: inadequate personal protective equipment or clothing (30%), weather condi-

Figure 2
Farmworker Occupational Injury Events Documented at Migrant Health Centers*



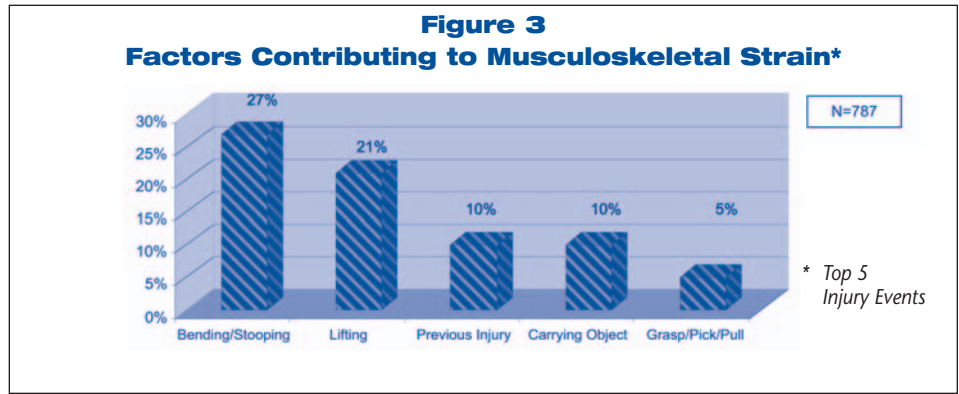
tions (17%), environmental exposures (14%), grasping, picking or pulling (11%) and crops being covered in poison ivy or sumac (9%) (only the top 5 contributing factors).

Chemical exposures were also notable injury events documented in the survey (5% of injury events) and typically involved exposures to pesticides or herbicides. Farmworkers complaining of chemical exposures usually indicated that the crop they were harvesting was covered in pesticides or herbicides (39%), or that they were engaged in mixing or applying chemicals (19%) and that they were wearing inappropriate personal protective equipment (8%) or working in the vicinity where spraying was occurring (7%).

Getting struck by an object (4%) and falls (4%) also accounted for a notable number of occupational injuries and illnesses. Inadequate personal protective equipment (27%), carrying an object (12%), pruning/trimming (12%) and faulty guards on machinery (7%) were associated with the majority of injury events leading to being struck by an object, while falls were frequently connected with getting on or off machinery (27%), a previous injury (19%), wet (18%) or uneven (18%) surfaces and faulty guards on machinery (9%).

Interestingly enough, many of the farmworkers visiting migrant health centers with these occupationally related medical conditions did not file workers compensation forms. According to data listed in patient charts, 90% of farmworkers chose not to file a claim for their work-related injury, while 3% did chose to start the claim process. In 7% of documented injury/illness cases, it was impossible to tell from the patients chart whether a claim had been filed. It is likely that the difficulty in filling out these forms, as well as the fear of reprisals from employers, influences the relatively low rate of compensation reimbursement.

As mentioned previously, data collection at emergency rooms was undertaken in one of the regions in New York and several cen-



ters scattered throughout the Northeast. The data presented here is from the last year of data collection in the New York region, which had the most comprehensive collection of ER data. We found that approximately 1/3 of occupational injuries and illnesses were treated at emergency rooms in this region (See Figure 4).

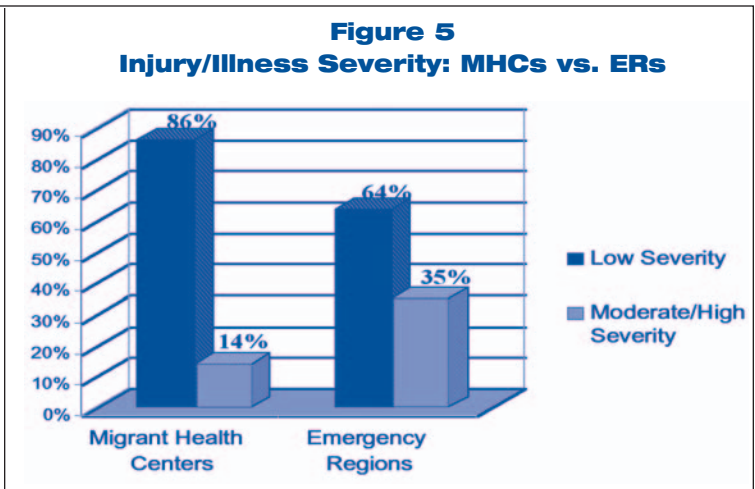
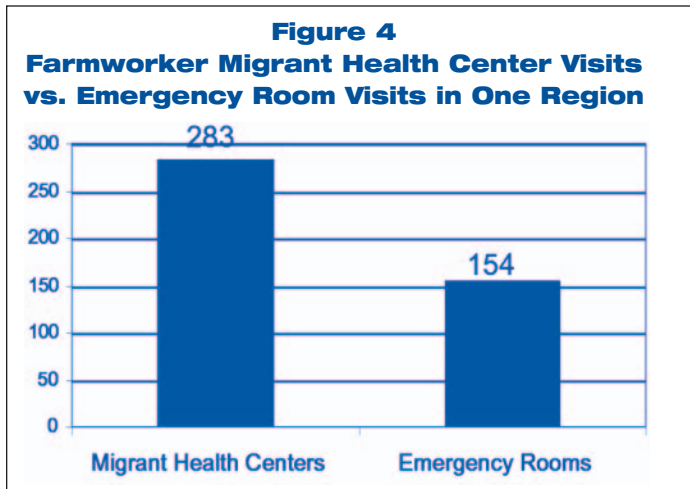
In examining this trend, we found that the majority of farmworker visits to emergency rooms involved treatment for work-related injuries that did not require urgent care. 64% of the farmworker occupational injuries documented at emergency rooms were of low severity (See Figure 5). This represents a drain on urgent care resources in this region, and most likely results in a loss of income for these institutions since the federal migrant healthcare program does not reimburse facilities for emergency room visits and most farmworkers do not carry insurance.

The results of our surveillance study indicate that occupational injuries and illnesses touch the lives of many farmworkers and their families in the Northeast. The resulting medical complications can affect a farmworkers income earning potential and/or quality of life and in learning more about the circumstances surrounding these injuries and illnesses, perhaps it is possible to involve migrant clinicians in prevention activities or at least to assist them in providing care for patients that

accounts for their unique job circumstances. NEC is currently using the data generated from this study to inform the medical community on the occupational health issues that are most salient in this population, as well as to design materials and safety training programs that reduce the incidence of these injuries and illnesses. Interventions that are currently underway at NYCAMH/NEC include ergonomic improvements to harvesting equipment, a physicians reference guide to farmworker occupational health, health and safety materials that are linguistically and culturally appealing to farmworkers, and safety training programs that take place at the workplace. Many of these projects will emphasize farmworker involvement in the development and design phases. For more information on NYCAMH/NEC research or intervention projects, call 1-800-343-7527. ■

References

McDermott, S. and C.V. Lee. 1990. Injury among male migrant farm workers in South Carolina. *J Community Health* 15(5):297-305.
 Ciesielski, S.D., S.P. Hall and M. Sweeney. 1991. Occupational injuries among North Carolina migrant farm workers. *Am J Pub Health* 81(7):926-927.
 Isaacs, L.K. and T.L. Bean. 1995. An overview of the Ohio migrant farmworker safety needs assessment. *J Agric Saf Health* 1(4):261-272.
 Villarejo, D. 1998. Occupational injury rates among hired farm workers. *J Agri Saf Health* 1:39-46.



The Challenges of Defining Migrant Workers

One of the challenges clinicians serving the underserved face is in trying to provide quality care to mobile patients. Among other concerns, health care providers must first be able to determine who is a mobile patient. In our work, we have found that there is no single definition of “migrant”. A quick internet search found the following:

- **Migrant:** “Habitually moving from place to place especially in search of seasonal work.” (HyperDictionary)
- **Migrant Worker:** “(A) person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.” (UN Convention on Rights of Migrants)
- **Migrant:** “A person who is or has been employed in hand labor operations in planting, cultivating, or harvesting agricultural crops within the last 12 months and who has changed residence for purposes of employment in agriculture within the last 12 months.” (State of Florida – migrant housing regulations)
- **Migrant:** “(S)omeone who changes residence, permanently or temporarily, across a geographical or political boundary . . . the term “migrant” is usually restricted to those who move voluntary (internally or internationally).” (Population Reports – Johns Hopkins School of Public Health)
- **Migrant Farmworker:** “(A)n individual whose principle employment is in agriculture on a seasonal basis, who has been so

employed within the last 24 months, and who establishes, for the purpose of such employment, a temporary place of abode. (Migrant Health Program)

- **Migrant Agricultural Worker:** “A person employed in agricultural work of a seasonal or other temporary nature who is required to be absent overnight from his or her permanent place of residence.” (Marshfield Clinic, Wisconsin)

Other issues to consider are that “Migrant Worker” and “Migrant Farmworker” are often treated as synonymous but they are not.

- Most day laborers doing construction and roadwork are migrant workers.
- Many people working temporary jobs in the service industry (hotels, restaurants, etc.) in seasonal vacation destinations are migrant workers.

“Migrant” and “Immigrant” are often treated as synonymous, but they are not.

- Though most migrants are immigrants, there are migrant families who have lived in the United States for generations (and who have usually been migrants for generations).

Migrants are not all from Mexico and Central America.

- Although the majority of migrants are of Hispanic / Latino descent, many also come from Jamaica, Haiti and Eastern European countries



Important questions to ask:

- What kind of work do you do?
- Do you move for work? Are you planning to move soon?
- Are you moving to somewhere new? Do you know where the clinic is there?
- Do you want a copy of your medical records to take with you? Do you have all the supplies / medications you need?

The most important thing is to open a dialogue so that your patient will feel comfortable talking to you about that fact that s/he is planning to move so that you can help find services. ■

Here are some helpful strategies to help providers identify “migrant workers”

If you want to know . . .	Ask . . .	Instead of . . .	Because . . .
Whether your patient is mobile.	“Are you planning to move out of the area anytime soon?”	“Are you a migrant?”	1. People confuse “migrant” and “immigrant” so if the individual isn’t an immigrant s/he may answer the wrong question. 2. It really gets at what you want to know – is this person going to leave your care?
Whether your patient is a migrant worker.	“Do you move for work?”	“Are you a migrant worker?” or “Are you a migrant farmworker?”	1. Same confusion with “migrant” and “immigrant” listed above. 2. People think “farmworker” when they hear “migrant” so you might not correctly identify people who are moving for construction or service jobs.
Whether your patient knows how to find care after s/he moves.	“Can I help you find a clinic in the area that you’re moving to?”	“Where are you moving to?”	1. Many migrant workers are in the country without documentation, they may be suspicious of questions about where they are going. Stating your real goal (helping find care) will increase your chances that someone will tell you where s/he is going.



Migrant Clinicians Network

P.O. Box 164285 • Austin, TX 78716

Non Profit Org.
U.S. Postage
PAID
PERMIT NO. 2625
Austin, TX

The following dates may be useful as you plan Health Education events:

October

- Breast Cancer Control Month
- Child Health Month
- Domestic Violence Awareness Month
- Family Health Month
- Flu & Pneumonia Campaign
- Healthy Lung Month
- Mental Illness Awareness Week (5-11)
- National Adult Immunization Awareness Week (12-18)
- National Breast Cancer Awareness Month
- National Dental Hygiene Month
- National Depression Screening Day (9)
- National Health Education Week (19-25)
- National Hepatitis Awareness Week (19-25)
- World Food Day (16)

November

- Child Safety & Protection Month
- Diabetic Eye Disease Awareness Month
- Flu & Pneumonia Campaign
- Great American Smokeout (20)
- National Alzheimer's Awareness Month
- National Brain Aneurysm Awareness Week (3-7)
- National Diabetes Month
- National Epilepsy Month
- National Osteopathic Medicine Week (5-11)

calendar

18th Annual California Conference on Childhood Injury Control

September 27-29, 2004
San Francisco, California
www.cipp.org

Fourth National Conference on Quality Health Care for Culturally Diverse Populations

September 28-October 1, 2004
Washington, DC
718-270-7727
www.DiversityRx.org/ccconf

17th Annual East Coast Migrant Stream Forum

October 21-23, 2004
Hilton St. Petersburg
St. Petersburg, Florida
The North Carolina Primary Health Care Association (NCPHCA)
919 469 5701 tel
800 277 6092 tel
www.ncphca.org

Fall 2004 Primary Care Conference

October 23-27, 2004
Salt Lake City, UT
Northwest Regional Primary Care Association
206-783-3004
www.nwrpca.org

The 14th Annual Midwest Farmworker Stream Forum

November 18-20, 2004
Adam's Mark,
Denver, CO
National Center for Farmworker Health, Inc.
(512)312-2700
(800) 531-5120
Lisa E. Hughes, hughes@ncfh.org
www.ncfh.org