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THE WORLD OF THE MIGRANT

Thirty-four million of the Nation's people are poor. Fourteen million of these - 40 percent of the total - live in rural areas. This reservoir of deprived rural people, especially in the Southwest and Southeast, is the source of the migrant farm labor force. Migrants number about one million.

The migrant's world

The world of the migrant differs in many ways from that most of us know. It is a world of brown and black faces populated by a minority comprised of many minorities - Mexican-American, Negro, Indian, Puerto Rican, and ~~low-income~~ Anglo-American.

It is a world in which "home" is a dilapidated shack in a migrant labor camp, located on a back road far from the main highway, overcrowded for family convenience or decency, with outdoor toilets shared with many other families and with an outdoor faucet or pump from 10 to 100 feet away as the sole source of water for all family use.

"Travel" represents not a comfortable trip with a vacation or a challenging job ahead, but a back-jolting ride for many weary miles in an overcrowded car, truck, or crewleader's bus to another uncertain job and another labor camp "home". Few or no stops may be made even when distances of several hundred miles are covered.

"Work" is characterized by hours from sunup to sundown, often in extreme heat, with no provision for toilets in the fields even though men and women work together, and with little or no protection of workers against the hazards of machines and toxic substances used in crop production and harvesting.

"Security" is earned from day to day. For some, security depends on their crewleader and on his ability to find good jobs and his willingness to treat both worker and employer with honesty and fairness. For all, it depends on weather and other hazards to crops, and on market conditions. The migrant worker has no unemployment compensation when his chance to earn is wiped out by floods, wind or hail storms, or falling market demands leave abundant harvests to rot in the fields. Nor are there welfare supports to sustain the family and assure it shelter, food and other basic needs in times of crop disaster or between seasons. As "citizens of nowhere" local welfare doors are closed to migrant families nearly everywhere. Lack of residence status to vote leaves them politically powerless, even if they knew how to use political forces to their advantage.

Some are vaguely familiar with a different and better world. When television sets bring it before them, they watch the well-dressed people in their middle-class homes pass before their eyes like citizens from Mars. Unfortunately no reverse TV program regularly presents the contrasting story of the migrant's life to middle-class Americans.

Concepts foreign to migrants

The incongruity of words like "belong", "neighbor", and "community" becomes conspicuous as you enter the world of migrants. An almost insoluble problem of determining identity may arise when a migrant worker dies in a camp. He may be known only by a nickname. He may have relatives or friends back where he came from, but no one knows where that is. He is anonymous to the grower in whose fields he works, to the crew leader who recruited him, to the family living next door in the camp.

"Belonging" is an unfamiliar concept in the sense of a migrant's being part of a local church, school district, labor union, farm organization, or community. Nor have local institutions or communities encouraged him to unite with them. Even as the migrant strives to obtain an economic toehold and settle permanently, communities often continue to be unresponsive and even hostile toward this perennial stranger. As an example, one growing midwestern town completely engulfed, but did not incorporate, the fringe area taken over by settling out Negroes and Mexican-Americans. Thus such community amenities as tax-supported sewer facilities, water, and trash disposal could still be denied them.

A report made 20 years ago said of the migrants - "Each harvest collects and re-groups them.....(They) engage in a common occupation, but their cohesion is scarcely greater than that of pebbles on the seashore." Their grouplessness as a way of life is not yet out-of-date in September 1963.

Whether to migrate at all is a question most migrants face each year. If "good times" in their home-base area provide a tenuous livelihood, a family may decide not to migrate. But this decision may be quickly changed by a labor recruiter's promises of better things "up north".

Local community attitudes

On the side of the local community, when efforts to improve migrants' health conditions are proposed, "Leave us alone; we are making progress" is often the answer. This expresses the attitude frequently found among employers of migrants, professional health workers, and other local residents who have some vague knowledge of the situation. Local physicians sometimes resist the establishment of night clinics in or near large labor centers as a measure to make medical care more accessible

and more acceptable to migrant families. They contend that no special effort is needed; no migrant will go without care if he asks for it. Yet, in one area in which such resistance occured, a local physician was heard to say ---- "I don't want these people stacked up like crows in my waiting room."

His statement conflicted strangely with the earlier heated denials that any migrant needing care would go without, whether or not he had money to pay. All that the migrant had to do was to somehow find his way to a local physician's office during regular office hours. Here he would stand to lose a day's pay while he waited. He would be subjected to detailed questioning regarding his ability to pay, and he would feel uneasy and unwanted while he sat for long hours with the physician's other generally affluent patients.

How migrants cope

The story of one family's coping with a health emergency illustrates the effect of our chaotic lack of system for delivering health care to people such as migrants. This story of the effect of the negative attitudes, policies and laws of community institutions and agencies on people who "don't belong" could happen in almost any community with an influx of migrants. The story is paraphrased from a California nurse's report.

A Mexican-American woman, Mrs. G., went to the county welfare department at 9:00 o'clock one morning. She waited until 4:00 p.m. only to be told that they could provide no help. They referred her to the health department. Here she again related her need for advice on how to get emergency medical care for her 3-year-old niece, Essie, currently with her parents in Texas. Essie's parents had formerly worked in the county but were now visiting an aged and ill grandfather in the Rio Grande Valley of Texas. After three weeks, Essie had become very ill

with a high fever which did not respond to home treatment. The parents took her to a doctor who referred them to a second doctor to verify the diagnosis of polio.

A third doctor at the local hospital refused to hospitalize Essie because she was not a resident. Instead, Essie's parents were told to take the child home, isolate her from others, and give her prescribed drugs. The drugs were costly, and all the family funds were gone, paid to the several doctors who had seen Essie. So Essie's father called her aunt collect in California to ask for the money to get the prescription filled. Mrs. G., already struggling with her own large family, did not have the money.

The nurse at the health department listened patiently to Mrs. G. Her department could offer no substantive help. The local Red Cross and Salvation Army offices suggested that their counterparts in Texas be called. The nurse started calling. It was the beginning of a three-day holiday weekend. No one could be reached at the local health department. The Salvation Army and Red Cross offices were closed.

The Texas telephone operator called the county sheriff. His wife was at home. She happened to be the executive secretary of the March of Dimes in the county. Through her, Essie was finally hospitalized. Essie still lives, but she requires physical therapy. Other care may be needed later. The $600 hospital bill remains unpaid.

Without the perseverance of her aunt and the public health nurse, Essie might well have died. Her story is not unusual. Our so-called health-care system often times seems to have little regard for individual human need especially when the needy person does not "belong" to the community.

Historical background

This problem of "poverty in motion" is far from new. President Theodore Roosevelt's Country Life Commission looked at the people of rural America including migrants in 1908. The Commission recommended improvements in housing, health and other conditions. National governmental committees and commissions from that time to the present day's Senate Subcommittee on Migratory Labor have ~~made~~ monotonously repeated such recommendations.

In the 1930's Carey McWilliams described the human misery of "Factories in the Fields" and John Steinbäck dramatized this misery in "Grapes of Wrath". The TV production, "Harvest of Shame," viewed everywhere across the land on a Thanksgiving Day a half-dozen years ago, stirred little more than a ripple of public controversy.

Only for about four years during World War II was there a sustained massive program to attack the multiple problems of farm migrants and their families on a national scale. At the war's end, Congress was in a great hurry to terminate all "emergency" programs. So the chronic emergency of the migrants set in again as the wartime program came to an abrupt end. Church groups were involved before, during and after World War II. They continued their efforts to help migrants who then, as now, were not quite citizens regardless of how long they had lived in the United States.

Migrant's handicaps

Looking at migrants as individuals, they suffer from many handicaps - skin color, language, lack of education and lack of skills in work outside of agriculture. They are also handicapped by the fact that they work in agriculture since hired farm labor has long been singled out for exemption from protective labor laws.

Added to their other handicaps is that of mobility, a handicap not just because they move, but because they are also poor. State and local legal restrictions against providing welfare aid to the nonresident or the transient "just passing through" are still fairly universal. Even where laws are liberal, interpretations may be narrow and the negative attitude of welfare workers toward those who "don't belong" may be just as effective as restrictive laws and policies in denying services to migrants. The welfare system, also, has built into it features such as degrading means tests, repeated at each new location under new criteria, which make many migrants avoid the doors of welfare agencies.

The Migrant Health Act

In the early 1960's, the Senate Subcommittee on Migratory Labor looked at migrant's multiple handicaps. In 1962, one of the package of bills introduced by Harrison A. Williams, Jr, the chairman, was passed. This was the Migrant Health Act. The Act was originally signed into law for a three-year period. In 1965, it was extended for another three years. Now legislation is pending before Congress to continue the program for an additional period.

The Act has opened many doors. It enables the Public Health Service to make grants to either public or private nonprofit agencies to help pay the costs of family health service clinics as well as other services, including inpatient hospital care, for migratory farmworkers and members of their families. More than 100 public and private agencies have taken advantage of the opportunity to pool local and State resources with the additional aid of a migrant health grant. Many have instituted organized systems for extending health care to migrants for the duration of their stay in the area.

Migrant health project development involves a commitment by project sponsors to non-traditional ways of providing services. This involves putting together the resources and services of public health and private medicine at a single time and place accessible to migrants, convenient for use by all family members, and offered under circumstances that contribute to use with self-respect and dignity. In a real sense, the services are a fringe benefit provided under community auspices for workers in an essential industry. This industry with few exceptions is not yet organized in a way that will readily permit the establishment of fringe benefit programs.

A few community projects use a mobile unit to take health services into the camps and the communities where migrants live. More often, the physicians, nurses, receptionists and clerks comprising the staff of a family health service center, move out several times each week to provide health care at fixed locations. Often a center uses improvised facilities in a community building such as a school house or church basement.

Project staff members use a great deal of creativity and flexibility to make their services as effective as possible. They also apply a great deal of human warmth and concern in getting acquainted with the migrant families in their own camp quarters and in teaching them about modern concepts of good health and health practices.

Migrant involvement

The involving of migrants, themselves, in self- and group-determination has been one of the national program's objectives, one requiring more ingenuity and creativity than any of the others. Group determination of need and ways to meet it can take place only where a group exists. In the group-less world of the migrant, a necessary first step is to help them achieve a sense of belonging to something that has meaning for them. In a world as shifting and with community ties as ephemeral as theirs, this is a challenge not easy to meet.

On the other hand, to assume that migrants are not a part of the community and must forever be dealt with accordingly would be to perpetuate one of their most severe handicaps--that is, their separation from community. Instead, somehow, they and the community must be brought together on the basis of interests that are mutually shared to establish goals toward which they can work together and which will benefit all.

Health, education and social services designed to reach migrant families effectively can be an entering wedge to this type of community development. But the design must be carefully developed if it is to help bring about a new sense of community for migrants and for local residents alike--a sense of community in which the world of the migrant and the world the rest of us live in become one and the same.

Challenge

In this effort individuals and groups, such as you and your organizations, have many assets. You have knowledge--knowledge of communities, knowledge of services, knowledge of ways to deliver services effectively, knowledge of ways to work with people. You are likely to be viewed as less threatening than public agency representatives by poor people such as migrants, and by the growers, the health providers, the school authorities, the church leaders, the business leaders, and the others in local communities who need to be informed and involved. Above all, you are women--women with love and compassion for those who have lived for too long on the bare fringes of our society.

In the single field of health, the 300 counties where projects are now receiving migrant health grant assistance have made a start. But less than half of the work is done. Approximately 400 counties lack any organized system of health care for migrants. Many of the project systems in the 300 counties now served are deficient in some services or in staff to do what is needed. The involvement of migrants with others in the community as part of the community health development team has barely begun.

There is also a continuing need to help communities understand that seeking solutions to the problems of migrants should involve practically all of us. Growers who employ them, local stores that cater to them, and consumers everywhere who enjoy the fruits and vegetables they harvest profit by their labor. In a very real sense, we need them.

In turn, they need us, and we owe them a response to this need. However, the funds allocated by Congress for migrant health can never be expected to meet the total health need, even when combined with other funds from other governmental sources which can be brought to bear. Our total authorization for the current fiscal year in the ~~pending~~ enacted legislation is $9 million - $9 per migrant - hardly enough to purchase much health care!!

But the seed money we have been able to offer has helped to catalyze action in communities of 300 counties. The Migrant Ministry and the Bishop's Council for the Spanish-Speaking were among the groups which, very early, saw in this seed money a means of overcoming the natural reluctance of communities which viewed the problem as not theirs alone but one shared with other communities. With the help of such groups the funds have stretched far beyond what would have been possible otherwise.

We come to you now with our hands nearly empty. To continue and adequately assist migrant health projects already operating would take all the funds we have and more. We appeal to you on behalf of the migrants

for help in creating the miracle that must take place if migrants are to be served, and to be brought with equality into our society.

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