

streamline

The Migrant Health News Source

Emerging Infectious Diseases and the Need to be Vigilant

Edward L. Zuroweste, MD- Chief Medical Officer, Migrant Clinicians Network

The appearance of H1N1 cases in Mexico in early April followed by cases being identified around the world triggered a barrage of activity among healthcare providers, public health officials and policy makers. This occurrence resulted in a number of important lessons- some good, some disheartening but all of them important.

On the positive side, members of the migrant health community rose up to make sure that migrant workers were remembered as an important patient population that often functions outside of the standard communication networks of information flow. The Migrant Clinicians Network issued a statement asking that migrant health providers stand in solidarity with their Mexican migrant patients and speak out against prejudice and irrational fear.

Another positive outcome came after being approached by the National Institute of Occupational Safety and Health (NIOSH) from the Centers for Disease Control and Prevention (CDC) with a concern that migrant workers who may have been exposed to H1N1 would have no way to be notified of any testing results or directed to care if necessary. Within twelve hours of the initial conversation, Health Network, the transborder patient navigation system that MCN has managed for more than 14 years was able to launch an H1N1 patient tracking component that would allow for the transfer of medical records, maintain communication with migrants possibly exposed and link these individuals to needed health care. Only a handful of migrants required the assistance but that fact that we were able to mobilize this comprehensive system for a new health concern so rapidly was a source of enormous pride for me. It also confirmed my belief that Health Network is an easily modifiable patient navigation system with application in disease surveillance, identification of at-risk



populations and treatment management for any number of injuries, illnesses or care needs among migrants.

On the disheartening side was the information that I received from a colleague concerning the disparity in time, attention and resources that were applied to H1N1 compared to tuberculosis. I received a short video by Hans Rosling of Swenden, Professor of International Health at Karolinska Institute and the Director of the Gapminder Foundation (<http://www.gapminder.org/videos/swine-flu-alert-news-death-ratio-tuberculosis/>) that lays out a number of disturbing facts. In the period between April 24 and May 6, 2009 cases of H1N1 were identified in 23 countries. Sadly, thirty-one of the individuals died during this period. At the same time 63,066 people died of tuberculosis (TB) disease. For each death by H1N1 the media issued 8,176 news items. Each TB death received 0.1

news items. This is stark reminder of the enormous role the media plays in determining the importance of a health concern. All death is disquieting but death from preventable or easily treatable diseases is shameful.

While the importance of rapid response and information dissemination about a potential health risk is evident, it is also critical that we not lose sight of the important public health battles currently in front of us.

The world is shrinking as rapid travel and ease of mobility make it possible to arrive anywhere in the world in a matter of hours. As I and others have said before, diseases know no boundaries. With the rapid and persistent movement of people comes the emergence of diseases that must not be ignored. We need to be mindful of what our patients may be facing in the future, but we also need to work hard to eliminate preventable and treatable illnesses that they are confronting in the present. ■

Ladders Raise Orchard Injuries

Helen Murphy, FNP, MHS

Orchard injuries are a major agricultural health and safety issue in Washington State, accounting for 45% to 58% of workers compensation claims. Because Washington is the No. 1 producer of apples, pears and cherries, this is an especially important concern.

To help workers in this industry, the Pacific Northwest Agricultural Safety and Health Center delved into the issue. To develop solutions, questions centered on the types of injuries, costs and circumstances of the accidents.

Step 1 was to examine all the Washington State Department of Labor and Industry's claims filed from 1996 to 2001 from the state's main tree fruit regions. This yielded 13,068 claims. Ladders were the No. 1 cause of orchard injuries, accounting for almost a third of all claims (4,020) and costing \$21.5 million over a six-year period.

Sprains and strains were the most common consequence from ladder accidents, but fractures and dislocations were more costly, accounting for \$7.9 million as a group. Examples of the stated causes on the claims were unstable placement of the ladder, overextension of the ladder's third leg, slipping while descending and being struck by a falling ladder.

To learn the circumstances leading to accidents, detailed stories were collected from 35 workers who had filed a ladder injury claim. Ladder movement was a contributing cause for more than half (65%) of the injuries and the main cause in 47%. More falls occurred on the upper third of the ladder than in the middle or lower positions. Slipping accounted for a quarter of the cases. Here is an example of an account:

The worker was picking apples on a 10-foot ladder on the seventh step with a full bag of apples. The worker was beginning to descend the ladder and turned to the right so that his back or side was to the rungs. The left foot slipped from the ladder, and the



worker grabbed the ladder with one hand and was left hanging. The hand was injured as well as the back. The worker attributed the injuries and severity to the weight of the bag, the slippery conditions and frosty weather. The three-legged ladder was set with the third leg to the outside of the tree.

These stories, while vivid and informative, only came from a small group of workers who filed a claim and were willing to be interviewed.

Solutions under way

To determine circumstances leading to ladder injuries, a larger group of 180 workers were questioned.

About 110, or 60%, reported that they had experienced an injury while working in the orchard; the majority (78%) of these involved a

ladder. Among the factors workers felt contributed most to injuries were ladders in poor condition, shifting weight of produce, bags and equipment in the way, poor weather, uneven terrain, and production pressures.

Several solutions are under development. The first is an engineering approach: replacing ladders with mobile platforms. This is rapidly being adopted by the tree fruit industry. Extension officers report increased productivity, fewer physical demands, and no accidents or claims filed to date related to platform work.

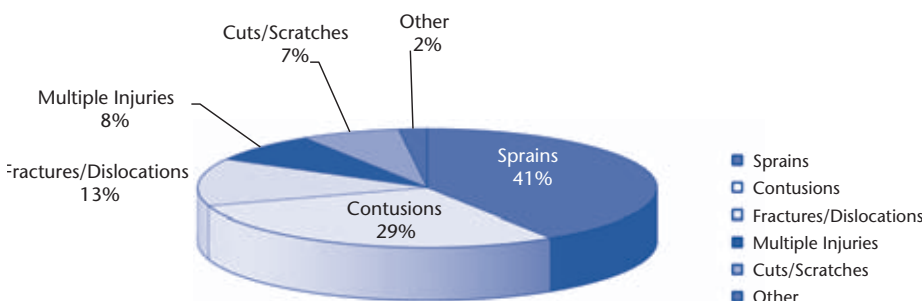
Until growers convert orchards to platform use, many will still need to use ladders. Final prototype testing is under way on a new "smart ladder" with sensors that provide information on the dynamic forces that lead to ladder falls.

The ladder can be equipped with warning signals to accustom workers to the stability limits of the three-legged ladder. This will help workers understand what risky activities or overreaching should be avoided.

A third solution is a new bag for fruit harvest that reduces the weight load for workers. The new bag, developed by researchers in New York State orchards, will be field-tested in Washington this fall.

For more information or references for this articles please contact Helen Murphy, 206-616-5906 or by e-mail at hmurf@u.washington.edu.

Types of Ladder Injuries



Policy update: Heat-related illnesses remain a significant concern for farmworkers

Pamela Rao, PhD, Farmworker Justice

After 12 farmworkers died from heat-related illness in the fields in 2005, the state of California adopted the country's first heat-illness prevention standard, which requires agricultural employers to provide water, shade, work breaks, and prevention training to their employees, and to develop a written plan for preventing heat illnesses on the job. Despite these measures, eight more workers died in California the year after implementation, and at least six died between May and August of 2008, including a pregnant 17-year-old. Compliance with the regulations remains low, with violations found in nearly half the workplaces California's Division of Occupational Safety and Health (Cal-OSHA) inspected in 2007.¹

In an attempt to avert more such tragedies, officials at Cal-OSHA announced on March 18, 2009, a campaign to increase awareness of the problem and educate workers and employers in advance of the height of the season for heat-related deaths, including a website for employers and workers with information in both English and Spanish.² Cal-OSHA will actively enforce the rules when the temperature reaches 85 degrees Fahrenheit. Following California's lead, Washington State implemented a heat-illness prevention standard in 2006 that became law in 2008.³ Workers in other states are generally protected by the federal Occupational Safety and Health Administration's (OSHA) Field Sanitation Standard, although some states do implement somewhat stricter standards (see "For More Information," below).

Heat-related illness occurs when the body is subjected to and/or produces more heat than it can dissipate due to ambient environmental factors or to physical activity. This is frequently the case for farmworkers, who may work in direct sunlight in activities that generate significant body heat while wearing heavy protective equipment. The resulting increase in core body temperature can lead to dehydration, electrolyte imbalance, and eventually neurological

impairment, multi-organ failure, and death. Depending on the type of work, personal factors, and environmental conditions, heat illness and death can occur in ambient temperatures as low as the mid-seventies Fahrenheit.

While employers are obliged to protect their workers from heat-related illness and deaths on the job by providing water, shade, and work breaks, patient education remains crucial for reducing the risk for heat illness. Health care providers who see farmworker patients for any reason should take the opportunity to remind them of the risks of heat-related illness in advance of high temperatures by reviewing:

- The need to develop a tolerance for working in heat ("acclimatize") early in the season
- The amount of water to drink during the workday
- The importance of taking frequent short rest breaks in the shade
- The benefit of working during the cooler hours of the day
- The importance of becoming acquainted

with the signs and symptoms of heat stress and monitoring their co-workers and themselves

For further information on recognizing, treating and preventing heat-related illnesses, please download Farmworker Justice's issue paper, "Heat-related Illnesses: An Occupational Health Concern for Farmworkers" (see link below). ■

References

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2. California Division of Occupational Safety and Health, March 18, 2009. "DIR partners with Ag Industry to Launch 2009 Heat Illness Prevention Training." Accessed April 26, 2009 at <http://www.dir.ca.gov/DIRNews/2009/IR2009-05.html>.
3. Washington Department of Labor & Industries, June 4, 2008. "L&I issues permanent rule on heat-related illness." Accessed April 26, 2009, at <http://www.lni.wa.gov/news/2008/pr080604a.asp>.

FOR MORE INFORMATION:

- Farmworker Justice. "Heat-related Illnesses: An Occupational Health Concern for Farmworkers." Available for download at <http://www.fwjustice.org/Health&Safety/resources1.htm>. In-depth review of heat illness among farmworkers, including clinical recommendations and references, language of the federal OSHA Field Sanitation Standard, and a chart of state modifications to the Standard.
- Washington State Department of Labor & Industries. "Outdoor heat exposure (Heat Stress)." Accessed April 26, 2009, at <http://www.lni.wa.gov/safety/topics/atoz/heatstress/default.asp>. Details, language, and educational materials about Washington State's rules.
- California Division of Occupational Safety and Health. "Heat Illness Prevention." Accessed April 26, 2009, at <http://www.dir.ca.gov/dosh/HeatIllnessinfo.html>. Detailed information about California's rule and links to heat illness and prevention materials in English and Spanish for employers and workers.
- United States Department of Labor, Occupational Safety and Health Administration. "Fact Sheet No. OSHA 92-25: OSHA's Field Sanitation Standard." Accessed April 26, 2009, at http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=Fact_Sheets&p_id=137. Details on scope of coverage, population, key requirements, and benefits.

New Findings from the Agricultural Health Study: Possible Association between Herbicides and Pancreatic Cancer

The National Cancer Institute has just published findings in the *International Journal of Cancer* showing a possible association between pesticide use and pancreatic cancer. Researchers conducted a case-control analysis and examined the potential associations between the use of

certain pesticides and pancreatic cancer. Their findings suggest that herbicides, particularly pendimethalin and EPTC, may be associated with pancreatic cancer, a rapidly fatal cancer. This work is part of the Agricultural Health Study, an important research effort that includes over 89,000

participants to explore potential causes of cancer and other diseases among farmers, their families as well as commercial pesticide applicators.

Andreotti G et al. Agricultural pesticide use and pancreatic cancer risk in the Agricultural Health Study Cohort. *Int J Cancer*. 2009 May 15;124(10):2495-500.

The Case For Putting an End to “Building Good Grower Relationships”: Why it is Time to Stop Discriminating Against Our Farmworker Patients

Mark Heffington, MD

Mark Heffington, MD FAAFP has practiced family medicine for over 26 years, and has worked in migrant health since 2001 as an outreach physician and medical director of Vecinos, Inc. Farmworker Health Program in North Carolina.

The unique health risks and obstacles to medical care faced by migrant and seasonal farmworkers are well known to those who are committed to addressing them, yet many healthcare workers do not realize how some of our own practices can actually exacerbate these challenges.

When discussing farmworker health risks, we include language and cultural barriers to health care access as well as the inherent risks of farmwork. We also recognize important factors such as avoidable pesticide exposure and other unsafe working conditions; poverty aggravated by exploitative wages and pay theft; unsanitary working and living conditions; and stress related to job insecurity, poverty, and lack of control of one's own life circumstances.

Contributing to each of these is the unique social position of the migrant farmworker, which Southern Poverty Law Center and others have described as “close to slavery.” Indeed, the relationship we generally see between the grower or contractor and the migrant farmworker has many of the characteristics of 19th century slavery. It is common for the grower or contractor to control not only the wages, conditions, and activities of farmworkers during working hours, but also their living conditions (often serving as landlord), what and when they eat, with whom they may associate, and when and where they may go outside of working hours. Fear of deportation or retaliation by their employers makes it difficult for workers to complain about pay issues, unsafe working conditions, unsanitary living conditions, or other forms of mistreatment.

Access to information about available social and medical services may also be controlled by the employers. When outreach services such as medical care are available for farmworkers, access to them is too often

controlled by the grower or contractor as well. Even in cases where workers are treated “humanely,” their freedom is still significantly limited by a large and unfair power differential.

Health professionals who care for migrant and seasonal farmworkers are very familiar with this situation. The “almost slave-master” relationship is spoken of openly, and often with an air of resignation, at regional and national forums. However, its underlying effect on the health of our patients and our obligation to address it as a healthcare issue are less often discussed and are not unanimously accepted. Some view the problem as beyond our scope, and others see it as simply an untreatable condition. A few even seem to believe that migrant farmworkers do not quite have the right to be treated the same as other patients. These attitudes lead unfortunately and inevitably to a paradoxical situation in which healthcare workers –who may be staunch advocates for their patients’ health when it involves prescribing medications or providing health education – become unwitting collaborators in perpetuating the underlying condition that contributes to so many of the farmworker’s health problems.

This unintended collusion is subtle but powerful. Conventional wisdom and established policy indicates that we must establish and maintain “good relationships” with growers and contractors, and be careful not to “make trouble for them,” so that they will allow us access to our patients, and in order to make things easier for everyone. This maxim may appear benign and practical on the surface, but it is based on the false assumption that the grower is entitled to the authority to control the access of “his” workers to medical care. It fails to recognize the patient’s autonomy, which is one of the pillars of the sacred patient-health provider relationship.

Maintaining this “good” relationship, by not “making trouble” for the grower would preclude or at least discourage us from reporting unsafe pesticide practices, unsafe working conditions, unsafe or unsanitary

housing conditions, or illegal child labor – even though each of these has negative effects on our patients’ health. And of course one would have to consider the employer’s concerns about work output and inconvenience when deciding whether to advise a patient to take time off for an appointment or to recuperate from an injury or illness. Simply by making this third-party relationship relevant, we betray our patient’s trust and deny his autonomy and primacy.

A common practice that illustrates this collusion is that of notifying a patient’s employer, or even more improperly, asking a grower’s (or landlord’s) permission to visit patients at home, especially when they are living on the grower’s property. This failure to recognize the patient’s right to visitation and association is often referred to as a “courtesy” to the grower/landlord, although it is really more of a discourtesy to the workers. It would never be considered appropriate for a home health care nurse or any other professional to ask permission of a non-farmworker’s boss or landlord to see a patient living on their property. However unintentionally, this practice clearly discriminates against the migrant farmworker.

This and similar behavior legitimizes and reinforces the slave-master mentality, even as it damages the patient-healthcare provider relationship. From the viewpoint of migrant workers, the healthcare worker has a cozy relationship with the all-powerful grower, and provides services only with his knowledge and blessings. It is unrealistic to expect a patient to share important sensitive personal information openly and honestly with health workers who are clearly aligned with, if not subservient to, the overseer who wields so much power over him.

Working in a completely mobile medical setting gives one a unique perspective based on more direct exposure to these issues. There is perhaps nothing more eye-opening than visiting patients where they live, seeing how they live and listening to their life stories as well as their medical

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issues. It affords many opportunities to witness first-hand the hard reality and the effects of the “close to slavery” phenomenon.

Since 2001, Vecinos, Inc. Farmworker Health Program has provided free medical services to thousands of migrant and seasonal farmworkers in western North Carolina. Our strict policy of treating farmworkers with the same respect for their autonomy and dignity that we offer to patients in all other healthcare settings is not always appreciated by growers, contractors, or even other healthcare providers. While at first, the idea of the provision of medical care to sick and injured farmworkers was generally well-accepted by their employers, some growers became uncomfortable, to say the least, when certain of our activities challenged the existing power differential. Because we understand the importance of the social determinants of health that affect our patients, we address them with education regarding safety, sanitation, and workers’ rights to fair pay and treatment, just as we do regarding other health issues. We also demonstrate to our patients their rights to autonomy and privacy by delivering services to them at their living quarters after their work hours without allowing their bosses to interfere.

Those growers and contractors who respect the rights and interests of their employees see no reason to object to our actions. But many others are quite angered by our refusal to recognize their authority over the lives of their employees. On more than one occasion, growers/landlords have asked local law enforcement to arrest us for trespassing on their property, where we were providing services to our patients who lived there. However, thanks to existing legal precedents recognizing farmworkers’ rights to visitation and association, none of us has yet spent a night in jail.

When our program was based in a county health department, several growers banded together and demanded that the board of health restrain us from giving our farmworker patients educational material regarding workers’ rights to safe and sanitary conditions and fair pay. The growers claimed that their workers had been quite satisfied with their conditions until we “interfered,” and that such matters were not the concern of healthcare professionals. We were required to appear at a hearing to justify our actions by explaining the concept of social determinants of health to the board of health! The board rewarded our efforts with warnings and additional procedural

requirements to attempt to limit our activities.

We eventually started an independent non-profit organization to house the program in order to avoid having to waste further valuable time dealing with local political pressures. Lawsuits were threatened against the program although none were ever filed. In general, we have found that after the initial outrage on the part of some employers, these and other threats abate dramatically. Perhaps it is because of the growers’ fear of public disclosure of their own activities, or perhaps their lawyers dissuade them for other reasons. But even after threats and other attempts to interfere with our access to farmworkers have failed, some growers have attempted to discredit us with our patients and have warned them not to associate with us. We were recently told by a group of patients that their employer claimed that the vaccinations we gave were “just water.” Workers have reported being warned by their bosses that we would turn them in to the immigration authorities. In spite of such actions, or possibly because of them, the workers continue to ask for and accept our services, and express their appreciation and trust in us.

We do not actively seek confrontation with growers or contractors, nor do we attempt to disrupt their business, but neither do we accede to them the power to prohibit us from providing care to our

What do you think of the issues raised in this guest editorial?

Does it resonate with your experience or do you have a different perspective to offer?

Please join the conversation on MCN’s blog
www.migrantclinician.org/blog.html.

We welcome your thoughts!

patients. We believe that both the farmworkers’ confidence in us as well as our ability to deliver good health care to them has been improved by our advocacy for our patients and by our unwillingness to align ourselves with their bosses. Because our allegiance is to our patients rather than to their employers, we do not hesitate to report violations of pesticide exposure, illegal child labor, and violations of migrant housing regulations to the authorities. Response from the agencies that supposedly exist to protect workers has been generally disappointing. But even more disappointing has been the realization that one of the reasons that our complaints are not taken as seriously as we would like is that so many migrant health programs, presumably limited by

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Are you working with health professions students? Direct them to our materials about pursuing an “Exciting and Rewarding Career in Migrant Health”

Migrant and Community Health Centers across the country are facing increasing challenges in recruiting primary care clinicians. Developing relationships with health professions educational programs is a tried and true method for recruiting clinicians. Hosting students from programs such as nursing and medicine provides an opportunity to expose future professionals to a career option they may not be aware of. It also allows health centers to observe students at work and to recruit those whom they feel would be an asset to their organization.

To assist students (or professionals considering a career change) to learn more about working in migrant health, MCN has developed a set of web-based resources. Visit the “Professional Development” section of MCN’s website (www.migrantclinician.org) and look for:

- “Considering a Career in Migrant Health” —an eight minute video featuring migrant clinicians practicing throughout the U.S.
- Tips and resources for pursuing a career in Migrant Health
- A Directory of Migrant Health Centers
- Continuing education and orientation materials for health care for migrant populations

A recent webcast entitled “Clinician Recruitment and Retention Strategies for Migrant Health Centers” presented by MCN’s Candace Kugel and Trish Bustos, Workforce Coordinator of the Northwest Regional Primary Care Association is archived and available for viewing at <http://www.cdnetwork.org/NewCDN/LibraryView.aspx?ID=cdn502>.

Please feel free to use these materials in any way and contact Minden Pletsch at mpletsch@migrantclinician.org for further assistance.



Migrant Voucher Programs Provide Needed Services to Farmworkers

Providing quality health care to a mobile farmworker population requires people and programs willing to work outside the established system of care. As highlighted in the November-December, 2005 issue of *Streamline*, some of the most innovative ideas in migrant health have come out of the *Migrant Voucher Programs* (MVP). The individuals working in these programs create a system of care for mobile patients by calling creatively on a wide variety of community resources.

Twenty-two of the 156 Migrant Health Centers provide migrant and seasonal farmworkers (MSFWs) with access to primary health care either wholly or partially as a *Migrant Voucher Program*. All MVPs coordinate, facilitate, and provide access to primary health care for MSFWs by purchasing, rather than providing directly, some or all of the primary care services required of 330 grantees. The common thread is that MVPs make primary care accessible nearer to the locations where MSFWs live or work, and that they do this through referral, case

management, collaboration, and/or by providing a voucher that an established care provider submits to the MVP for reimbursement under a defined service agreement.

This service delivery model has been in existence since the 1970s. The model is defined by HRSA as follows (<http://bphc.hrsa.gov/policy/pin0801/definingscope.htm>):

Migrant Voucher Programs are established when there is insufficient sustained demand in an area for health care services from migrant and seasonal farmworkers to warrant establishing a permanent or seasonal service site. Often migrant voucher grantees do not provide direct health care services; rather, the grantee may establish a screening site(s) where the clinical needs of a patient are assessed and then a referral for care is made to a local provider through an established contractual arrangement. The local provider will provide the primary care services to those individuals who are referred by the voucher program.

MVPs can vary depending on the need and existing resources in a particular area. Depending on local needs, the MVP can use a combination of service delivery approaches and reimbursement mechanism to increase access to health care for farmworkers. Community involvement plays a vital role in voucher programs through community health workers, public health nurses, health educators and lay health promoters who perform outreach services to determine patient eligibility, and provide health education, case management and patient navigation to primary and specialty services.

There can be significant barriers to seeking out and receiving care for mobile farmworkers. Many patients are not familiar with where the health care facilities are in their area and have difficulty navigating the health care system due to language and cultural differences. Culturally competent staff of MVPs specialize in reaching out to these populations with each program being designed to address

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the unique needs in their region.

In one example of a Migrant Voucher Program, the Maine Migrant Health Program provides direct and contracted primary and preventative medical and dental services statewide. It provides outreach, health education through the use of promotoras, case management, pesticide safety training, transportation, and a Farmworker Resource (Rakers') Center. The program has a statewide referral network of over 45 providers.

The North Carolina Farmworker Health Program offers a statewide program located within North Carolina's Office of Rural Health and Community Care. It provides increased access to health care for MSFWs and their families in NC. The program utilizes contracts and fee-for-service reimbursement to support enabling services, primary care, behavioral health services, dental care, specialty care and X-ray and laboratory. Based on a nurse and case manager outreach model to link farmworkers with services, its role includes capacity building of local agencies and statewide advocacy.

Community Health Partnerships of Illinois, which was profiled in the 2005 Streamline article, also utilizes a nurse-managed system of care to reach the dispersed farmworker population in the

state, as well as providing direct dental and medical services.

The design of MVPs allows for a variety of strategies to increase access to health care for MSFWs and reach those who struggle with acquiring needed health care services. MVPs are ideally suited to target the hardest to reach of an already hard to reach population. As such this model is ideal for regions that would not sustain a free standing migrant health center and it also is able to fill gaps in a state's or region's health care system.

MVPs specialize in caring for MSFWs through the development of culturally appropriate outreach which addresses many of the unique barriers faced by MSFWs. The MVPs also allow for a great deal of flexibility in responding to the seasonal needs of MSFWs.

History has also shown that the MVP model can be very cost effective because resources used in locations or time periods with the most need. Additionally the MVPs utilize local provider networks and thereby actually support the local system of care. The MVP programs operate with a very low fiscal overhead and are able to leverage significant in-kind contributions.

The MVP model of care also presents some unique challenges. The majority of care delivered by MVPs is uncompensated because most MSFWs fall below federal

poverty level and are uninsured. For the relatively few MSFWs who might have Medicaid or Medicare coverage, "off site" visits purchased by MVPs from private practitioners are not eligible for FQHC reimbursement to the MVP. These funding constraints make MVPs much more dependent on grant funding.

MVPs are also challenged by UDS data collection and BPHC performance measures, because the MVP model differs so much from the traditional health care service model. The data collected does not include many of the standard services provided by MVPs such as case management, referral and outreach services.

In spite of these challenges, the existing MVPs continue to serve as a unique model of care that is particularly well suited to a transitory MSFW population.

For more information about the Migrant Voucher Programs you can view an archived webcast presented on March 4, 2009, featuring Elizabeth Freeman Lambar, CEO, North Carolina Farmworker Health Program and Barbara Ginley, Executive Director of Maine Migrant Health Program entitled "Migrant Health Voucher Programs" <http://www.cdnetwork.org/NewCDN/LibraryView.aspx?ID=cdn492>.

MCN's website, www.migrantclinician.org also features program resources specific to MVPs. ■

■ Why it is Time to Stop Discriminating Against Our Farmworker Patients *continued from page 5*

their friendly relationships with growers, have not reported the numerous and egregious offenses that we have heard them talk about "off the record." This makes it appear to officials that the problems aren't really significant and that we are simply overly-zealous outliers.

What can and should we as migrant healthcare providers and outreach workers do to avoid perpetuating the health-endangering, "close to slavery" predicament of our patients? First, we must accept the responsibility for assessing and addressing not only the superficial medical needs of our patients, but also the important underlying causes of their health risks and obstacles to health care. Therefore we should not participate in the discriminatory treatment of farmworkers any more than we should encourage asthmatics to smoke. It is important to honestly examine our own attitudes toward our patients, recognizing and

addressing any condescending or patronizing ideas that may have made their way into our consciousness. We have to be careful not to allow such often-heard phrases as "at least it's better than they had it in Mexico" and "what can they expect, since they are illegal?" affect how we view our patients.

Respecting our patients' dignity, autonomy, and privacy requires refusing to recognize or legitimize the authority of growers or other third parties to control their access to health care. We can do this by stopping the antiquated and shameful practice of asking growers or landlords for permission to make home visits to our patients. As Carol Brooke of the North Carolina Justice Center notes, "It's important for workers to know that health providers acknowledge their legal right to have service providers and other visitors of their choosing."

In our interactions with patients and with their employers, we must make it very clear that we do not work for the growers or contractors, nor are we dependent on their blessings. Our position on the front line often makes us the only witnesses to the abuses that farmworkers face, and our obligation to improve our patients' health makes it part of our job to work to end them.

Our country looks back in shame at the practice of slavery in our history. We wonder how people with good intentions could have allowed it to exist for so long without acting. Future generations will no doubt wonder how healthcare workers could have participated in the discriminatory treatment of migrant farmworkers that exists today. Now is the time for us to end that participation and to work for change, for the sake of social justice as well as for the health of our patients. ■



Migrant Clinicians Network

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calendar

IV Summer Institute on Migration and Health

June 29th-July 3rd, 2009
Puebla, Mexico
www.regonline.com/IVcursointernacional

National Conference on Ending Homelessness

July 29-31, 2009
Washington, DC
<http://www.signup4.net/public/ap.aspx?EID=2009194E&OID=50>

2009 Convention & Community Health Institute

August 21-25, 2009
Washington, DC
National Association of Community Health Centers
<http://iweb.nachc.com/Events/>

2009 East Coast Migrant Stream Forum

October 22-24, 2009
Atlanta, GA
<http://www.nccchca.org/>

2009 National Environmental Public Health Conference - Healthy People in a Healthy Environment

October 26-28, 2009
Atlanta, GA
<https://www.team-psa.com/2009nephc/main.asp>

17th Annual HIV/AIDS Update Conference and Border Health Summit

October 27-30, 2009
South Padre Island, TX
<http://www.valleyaids.org>

NWRPCA Fall Primary Care Conference

October 24-28, 2009
Seattle, WA
<http://www.nwrpca.org/>

The 2009 National Primary Oral Health Conference

November 1-5, 2009
Nashville, TN
<http://www.nnoha.org/calendar.htm>

137th APHA Annual Meeting

November 7-11, 2009
Philadelphia, PA
<http://www.apha.org/meetings/>

The 19th Annual Midwest Stream Farmworker Health Forum

November 19-21, 2009
South Padre Island, TX



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