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Mexican American Migrant Farmworkers and Health Care in Wyoming: An Analysis of the Wyoming Medicaid Policy as it Pertains to Migrant Families

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Mexican American Migrant Farmworkers and Health Care in Wyoming: An Analysis of the Wyoming Medicaid Policy as it Pertains to Migrant Families

A thesis submitted to the faculty of Carroll College in consideration for graduation with honors

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Helena, MT
January 1999
This Thesis for honors recognition has been approved for the Field of Spanish.

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Abstract

The migrant lifestyle has posed difficulties for health care providers over the course of this century. The constant relocating and the poverty migrants face create a variety of health care problems. Migrant workers must be targeted and sought out by migrant health programs across the nation so as to ensure the health of our nation's agricultural laborers. In Wyoming, Mexican American migrant farmworkers return annually to work in the sugarbeet fields in the Big Horn Basin. The Wyoming Migrant Health Program actively seeks out these migrant workers in order to provide basic health care to both the workers and their families. Yet the Migrant Health Program meets only their basic health care needs. In order to ensure that migrants do not slip through the health care cracks, Wyoming must make Medicaid accessible to qualifying migrants.
Introduction

Rolando, a 15-year-old migrant worker, enters the migrant clinic in Powell, Wyoming, at 7 PM with his parents Isabel and Raul. He complains of a pain in his left side. The nurse practitioner examines the young man and decides that it is just stomach pain and not appendicitis. But she clarifies that if his condition worsens he must go to the emergency room.

At 11 PM Rolando can bear the pain no longer. His parents drive him to the emergency room. He is immediately diagnosed with appendicitis. Operation must be done immediately. Luckily, they arrived in time. The appendix has not burst and is removed easily leaving Rolando alive and well. After two days, he is released from the hospital for a complete recovery at home. His parents thank God that he is all right but pray for a solution to the new found financial problems.

Rolando and his family are migrant workers. They belong to a small and largely invisible culture in our society. The population of migrant workers and dependents in the United States is estimated at around 4.2 million but this number varies greatly (Dever, 1991). This variation is due to the fact that a transient population is hard to count and due to a lack of a standard definition of migrant worker. Migrant farmworkers, as defined by the Wyoming Migrant Health Program are “farmworkers... who move from place to place to do farmwork.” Also, their principal source of income must come from farmwork.

Historically migrant labor has been used in the United States since its creation. Migrant labor links back to slavery, but with the abolition slavery and the opening of the West new sources of cheap labor had to be found. (Johnston, 1985).
The cession of Mexican territories to the United States added new Americans to work the crops. The Mexican Revolution, WWI, and WWII brought Mexicans to the United States. Also, many Mexicans have immigrated illegally into the United States. These historical sources have formed the Mexican American population we have today. From this population the Mexican American migrant population arose.

This thesis specifically focuses on these Mexican American migrant workers and their families. More specifically it looks at the migrant workers and their families that come to Wyoming each May. The majority of these workers today come from south of Eagle Pass, Texas, the South Texas Valley (Larson, 1997). They come to Wyoming to work primarily in the sugar beet fields. They thin and weed the fields by hoeing, jobs no one else in the area will do. The migrants’ work is important to the sugarbeet industry. Their work is an economic contribution to the state. The majority of this work is done in the Big Horn Basin. The “Basin” consists of Fremont, Bighorn, Park and Washakie counties. It is an arid region made fertile by irrigation. Migrants have been coming to Wyoming since the early 1900s to work the sugar beet crops. They came during WWI and WWII and many still make the yearly pilgrimage today.

Migrants have created a culture of their own through the course of history. They are Mexican Americans but their lifestyle has mandated a distinct culture. Migrants follow three general streams of work: East Coast, Mid-Continent and West Coast (Johnston, 1985). In following these streams yearly migrants have created a lifestyle that changes with the seasons. Their style of living has constructed a culture that is perpetually in motion yet built upon a solid family. Migrants are poor yet
proud. For the most part they are undereducated and an under-served population. Migrants' poverty and transience makes life difficult, but through all the toils migrants face they are a happy people.

These migrants are United States citizens but are more often treated like undocumented workers. Migrants work in the second most dangerous occupation in the US, agriculture, (GAO, 1992) and often they have little control over employment conditions. They earn little money and are limited by seasonal employment. Housing conditions also are unstable (Sandhaus, 1998). These factors combine to put the migrant population at a distinct disadvantage in terms of personal health.

Migrant health is never at the head of national health care reform though the challenging conditions migrants lived and worked in were first noticed in the 1940s. These conditions led to poor health for migrants. This problem was again addressed in the 1950s by the Public Health Service (Johnston, 123). The first formal legislation to dedicate money to migrant health was signed by John F. Kennedy in 1962. Since then migrant health programs have seen gains in programs offered and people served but increased funding has not matched inflation (Johnston, 1985).

The Wyoming Migrant Health Program has existed for twenty-five years. During this time it has done its best to provide basic health care for migrants working in the state. The WMHP was directed by NOWCAP (Northwest Community Action Programs of Wyoming) but since 1997 has been directed by the Wyoming Reproductive Health Council (WRHC). The WRHC made changes to improve the program and to make it more accessible to the migrants. But, migrants still suffer
from the same problems now as they did 25 years ago. The WMHP does not have sufficient funds to deal with the myriad of health problems migrants face.

Medicaid is a joint federal and state health care program for low-income families in the United States. It is the largest publicly funded program of this kind in our country. Although it has the most funds it still leaves many Americans uncovered (Feder and others, 1992). Medically needy applicants for Medicaid qualify only if they live at or below 53% of the Federal Poverty Level (Feder and others, 1992). Also, Medicaid is a federal/state program and application is done at the state, not the national level. Many states have residency guidelines in their State Medical Assistance Manuals. The residency guidelines claim that a person must be a resident of the state to qualify for Medicaid in that particular state. Migrants from the South Texas Valley working in Wyoming fail to qualify in many instances because of this policy.

Mexican American migrant workers have given a lot of themselves to this country. They are essential in harvesting our nation’s crops. Over 85% of the produce harvested and cultivated in the US in the last decade was done by hand (Oliveria, 1993). The migrant and seasonal farmworkers harvesting these crops are grossly underpaid. Roughly half of all migrants live below the federal poverty level (National Advisory Council on Migrant Health, 1993). The small wages that these workers earn subsidize our nation’s produce market. In return they have received low wages, poor working conditions and in turn poor health. They pay taxes just like all American citizens. As citizens they help pay for Medicaid but are often unable to access Medicaid coverage simply because they are not in their home state. The
parents of Rolando, the boy with appendicitis, would be faced with extreme financial difficulties in the state of Wyoming. Wyoming must understand that these people have contributed both culturally and economically to our state and grant them equal access to Medicaid.

**Migrant History**

The history of the Mexican American migrant farmworker is as inconspicuous as the migrant population itself. Viewed over the course of time their history begins, disappears, and reappears in different times and locations. Their history is as hard to track as the migrant worker, yet like the migrant worker it is intimately linked with a heritage of which Americans are proud, our agricultural roots.

The tradition of migrant labor began in the US with slavery. The first slaves in America were Native American Indians (Weathorford, 1992). In the 1600s, indentured Europeans formed a cheap pool of labor for the colonies. The importation, or the forced migration, of black slaves from West Africa began in the 1600s and provided a continued supply of free labor until the formal abolition of slavery in 1865 (Johnston, 1985). After abolition migrant labor took on a new meaning as the West opened up and was settled (Crawford, 1994).

The history of the Mexican American migrant farm worker begins in Mexico, or what was once Mexico. California, Utah, Nevada and large portions of New Mexico, Arizona, Colorado and Wyoming were Mexican Territory. The Texas Rebellion of 1836 resulted in an independent Texas, but also served as a catalyst for the Mexican-United States War (1846-1848). In 1845 Texas was annexed by the
United States and in 1848, the Treaty of Guadalupe Hidalgo ceded this territory, more than one-half of Mexico's pre-war territory, to the United States (Kirstein, 1977).

These new citizens of the United States did not, however, enjoy the gains to be made in the American West. Although native to the land they were forced off and out of their own property through violence and deception. These "new" Americans were subjected to racism and treated as second class citizens. Yet, this strong-willed people persevered. These Mexican Americans adjusted. They worked the large cotton farms of the Southwest while at the same time making significant cultural and economic contributions to the region (Kirstein, 1977).

In the mid 1800s crop specialization was relatively unheard of in Northern and Midwestern states. Crops could be managed with help from family and neighbors during peak seasons of labor. In southern states where cotton was mass-produced, slaves filled the need for hands. But in the late 1800's crop specialization spread. Small family farms were consolidated under larger farming enterprises. The land began to be worked by machinery, and inventions such as herbicides (1850s) aided crop specialization. With the new technology came higher costs that had to be supported through large-scale operations. However, as farming became a big business, it depended more and more on migrants during peak labor intensive times to do jobs that technological advancements could not (Johnston, 1985).

From the capturing of Mexican territories until the Mexican Revolution (1910-1917), immigration of Mexicans to the United States was relatively slow. But during the Mexican Revolution many refugees crossed the border searching for stability and work (Crawford, 1994). From 1910-1920 approximately 250,000
Mexicans immigrated legally into the United States compared with 24,000 between 1900-1910. World War I was fought (1914-1918) bringing US involvement, and in turn, a shortage in labor as young American men left the farms to fight. This factor in tandem with the Mexican Revolution pulled more Mexicans into the United States to ease labor shortages (Kirstein, 1977).

These Mexican workers did not solely work crops in the Southwest, although the majority did. The improvement of the nation’s roads and the railway systems allowed for produce from the interior of the nation to be transferred faster and to further destinations. It also made regions outside of the Southwest available to Mexican migrant workers. Employers obtained these Mexican workers by paying Mexican contractors to truck laborers to the US (Kirstein, 1977). By 1920, the increased mobility of the migrant farm worker had established three general travel patterns of work or migrant streams: East Coast, Mid-Continent, and West Coast.
With the onset of WWII (1939-1945) the United States once again turned to the south, to Mexico, for help with labor shortages. In 1942, the “Bracero Program,” an international work agreement, was signed by the two countries (Crawford, 1994). This program was used to contract single Mexican males to serve as temporary agricultural workers in the absence of US citizens. The majority of the braceros were experienced agricultural laborers who came from important agricultural regions of Mexico (www.farmworkers.org/bracerop.html). These workers came alone and were not allowed to bring family members with them (Crawford, 1994). Simon and Schuster’s International Dictionary defines a bracero as a “man who offers his arm as a support.” In economic terms it has come to mean, “a male laborer who is legally contracted from the Mexican government by the United States government to work for American farmers” (Herrera-Sobek, 1979). Braceros seeking work in the US were first subject to a health inspection at the border. Then, after signing an agreement few could understand due to language differences, they were trucked or freighted to regions in the nation requesting aid in agricultural work (Kirstein, 1977).

The bracero program era established a precedent for how migrant workers would be treated legally. The program was outlined in a legal document signed by Mexico and the US that granted Mexican braceros a minimum wage and outlined specific social conditions to be followed in their treatment. Agribusiness though, with powerful governmental connections was able to ignore and, in many cases, thwart some of the major components of the international agreement. The agreement stated that no Mexican worker could be imported to do a job unless it could be proven...
that a domestic labor shortage existed. In many instances labor shortages were invented so that farmers could use the cheaper migrant labor (Kirstein, 1977).

To compound this problem, the influx of undocumented workers increased greatly during this same time frame. Undocumented workers had no legal rights in the United States. They were forced to work under horrible conditions for little pay with the knowledge that there were others that would gratefully take their place. The undocumented workers would say nothing to government officials due to a fear of deportation (Johnston, 1985). Farmers, accustomed to traditional agricultural labor standards in which employer-employee relations were not government regulated, often preferred undocumented workers because they could pay them even cheaper wages and did not require the bureaucratic hassle bracero workers entailed (Kirstein, 1977).

The bracero program was terminated in 1947 due to a return of former soldiers to the agricultural workforce, but also because of the undercutting by undocumented workers. Due to this undercutting, increased border control legislation was passed to curb the influx of undocumented Mexican workers. Along these same lines the bracero program was reestablished in 1951 as a "bi-national labor agreement" under Public Law 78. It was hoped that braceros would displace undocumented workers and in turn slow illegal immigration. This did not occur. In reality illegal immigration remained steady and the new implementation of the bracero program further saturated an already abundant labor force. This allowed braceros basically to be treated as undocumented workers. The braceros knew that if they did not work for the wages and conditions outlined by the grower they could
easily be replaced by undocumented workers. Also, in 1954 Public Law 78 was amended by Public Law 309 which allowed the policies established for workers' rights to be undermined, "...after every practical effort [had] been made by the US to negotiate and reach an agreement on such arrangements" (Kirstein, 1977). Agribusiness' sway on governmental policies allowed them to continue acquiring cheap labor from Mexico even though farm unions argued strongly that the labor shortages were only due to the fact that the wages and working conditions were unacceptable to American workers (Kirstein, 1977).

For these fundamental reasons the bracero program failed. With the election of President John F. Kennedy and a heightened social awareness in the 1960s things began to change. The bracero program was increasingly viewed as typically exploitative of Latin America and unjust to American farmworkers. For these reasons it was finally brought to a permanent end in 1964 (Kirstein, 1977). In this light, termination seems a good thing, but economic troubles in Mexico, caused by exploitation of the country's labor force and resources by transnational corporations mainly from the US, pushed workers to continue seeking work in the US. This constant influx of workers perpetuated the exploitation of both documented and undocumented migrant workers. (Kirstein, 1977).

From the signing of the Treaty of Guadalupe Hidalgo, to the continuing influx of Mexicans into the United States in search of work, the Mexican American population became well established. According to the 1990 population census there are 13,496,000 Mexican Americans in the US (US Census Bureau, 1998). Within this population though, a unique sub-population, tied to agriculture due to necessity
or tradition, has been formed. A few migrants are descendants of those who made a
living off the land before it was property of the United States. Other Mexican
Americans have followed in the footsteps of kin that came during the Mexican
Revolution and WWI. Many migrants today are children of former braceros who
eventually brought their families to the U.S. Many are descendents of once illegal
immigrants who worked the fields and eventually obtained U.S. citizenship. Others
are new to agricultural labor, forced into the migrant lifestyle for lack of work in
different regions of our nation. From wherever they come, these Mexican American
migrant farmworkers have created a niche in American society that must be
recognized.

History of Migrants in Wyoming

In Wyoming the sugarbeet industry played the pivotal role in bringing
migrants to Wyoming. Sugarbeets were first planted in the Big Horn Basin near
Worland in 1905. This same year the railroad into Worland was completed. By 1909
growers were under contract with sugar companies to grow sugarbeets. Sugarbeets
demand a lot of back-breaking manual labor (Holly Sugar, 1992).

Working in the beet fields in the early 1900’s was difficult work. The short
handle hoe was widely used and required the user to work bent over, crawling over
the beet fields all day (www.farmworkers.org/shorthoe.html). Early in the spring the
sugarbeets had to be “blocked.” Blocking consisted of hoeing the rows to make sure
each individual plant was separated from the next to allow optimal growth. Next the
field was thinned. During thinning workers remove as many weeds as they can by
hoeing between the plants. The third stage is called weeding. Weeds missed during
thinning were then removed by pulling or cutting them out of the ground (Holly Sugar, 1992). During the harvest the beets were first topped. Topping the beets consisted of cutting off the upper part of the beet and the leafy part. Migrants topped the beets with a tool “that resembled a razor-sharp machete with a mean, semi-curved, three or four-inch hook riveted on the end” (www.farmworkers.org/shorthoe.html). Topping was done because this part of the beet contains little sugar and can be used instead to feed cattle and sheep (Kilroy, 1996). The final stage was harvesting the beets from the field. Harvesters pitchforked the beets into horse drawn wagons that hauled them to beet piles near the railroad (Holly Sugar, 1992).

The sugarbeet crop began to draw workers to Wyoming in the early 1900s. The first laborers in the sugarbeet fields were young Mormon men, but families from Japan, Russia and Germany also settled in the Basin to work the sugarbeet fields. Families from Mexico and other Mexican Americans, mostly from New Mexico, made a yearly pilgrimage to work in the beet fields. The combination of these work forces provided a ready supply of labor for the sugar companies. (Hewitt, 1982).

Many small Mexican American populations were established in rural Wyoming towns associated with agriculture (Hewitt, 1982). In the first half of the century many regions of the state grew sugarbeets. The Big Horn Basin, consisting of Big Horn, Fremont, Park and Washakie counties, has always been the major region for sugarbeet production. Outside of the Basin sugarbeets were grown around Sheridan in Sheridan County, Buffalo in Johnson County, Torrington in Goshen
County, Wheatland in Platte County, Pine Bluffs in Laramie County, and in Crook County (Hewitt, 1982).

In towns where Mexican American communities flourished such as Worland, Powell, Lovell, Greybull, and Torrington, these workers displaced other labor groups, namely Russians and Germans. In 1918, in a response to WWI, Mexican laborers were actively sought to fill acute labor shortages. “Recruiters for the sugar companies loaded special trains with Mexicans in El Paso, Texas, for transport to Denver then to Wyoming and Montana” (Hewitt, 1982). Yet, despite the valuable niche they filled in the agricultural economy, they were generally treated poorly. “After they arrived they found poor housing, low wages, and prejudice. Discrimination in bars, pool halls, churches, and restaurants was ignored by Great Western Sugar and persisted until after WWII’” (Hewitt, 1982).
Paul Rodriguez, Jr., former migrant and now manager of Wyoming's largest beet farming operation, recalls settling in Wyoming near Powell in the 1930's.

"There used to be a lot of prejudice toward Mexicans here at one time. There's still a lot of bitterness towards the community by my relatives who once lived here and that is why most of them went to California. I can remember when I couldn't swim in the swimming pool in Powell and there were signs in many of the bars, cafes, and barbershops prohibiting Mexicans" (Wallace, 1978).

The Rodriguez family began in the beet fields in the Basin when Paul Rodriguez Sr. met his wife to be, Antonia, in 1929. The young Rodriguez family migrated between the beet fields in Wyoming and New Mexico during the first few years of their marriage (Wallace, 1978). The movement of migrant workers to the beet fields in Wyoming from New Mexico greatly increased during WWII. Sociologist Charles P. Loomis charted the migration of New Mexicans from Taos and San Miguel counties to the agricultural communities in Wyoming (Hewitt, 1982).

By WWII, a couple of predominant stereotypes had been formed about Mexicans by the people of the West. People assumed that since most Mexicans came from rural roots that they were well suited for agricultural work. Secondly, Mexicans were seen as docile because they worked hard for long hours for low wages with very few complaints. These two stereotypes greatly influenced the treatment Mexican workers received in Wyoming (Hewitt, 1982).

WWII took 22 to 39 percent of the agricultural workforce throughout the state of Wyoming leaving the agricultural economy vulnerable (Hewitt, 1982). Women, school children, and businessmen were recruited to harvest the crops. Also, Japanese
living in the Heart Mountain detention camp were forced to labor in the fields. A group of Kickapoo Indians came yearly to work in the Basin from southern Texas (Pendergraft, 1985). Labor shortages still abounded so state and local officials sought a more permanent solution to the problem and turned to the bracero program to fill labor shortages.

From 1942-1945, Wyoming actively pursued braceros. Under the bracero program Mexican workers, “would not be subject to military service, would not be discriminated against and would enjoy guaranteed living expenses and the prevailing wage in the areas they worked.” (Hewitt, 1982). Despite these guarantees, promises of the agreement were often ignored.

Recruiting of braceros mandated the construction of living quarters for migrant workers. Beet worker houses were constructed. They were, “often little more than shacks, with outdoor plumbing, and a well in the backyard as the water supply.” The Mexican workers with Holly Sugar, “were maintained in a ‘Mexican Colony,’ a group of stucco houses located on the west side of the Bighorn River (just outside of Worland)” (Pendergraft, 1985). Loretta Alcaraz, lifetime Worland resident who has worked with the migrants her entire life, remembers these times as a little girl. She recalls migrants being housed in shacks where sheep had been penned and where chemicals were stored. She remembers the men arriving with nothing but the clothes on their backs. Her father gathered and distributed clothes and blankets to them. It is important to remember that spring temperatures in Wyoming often dip below freezing in the early morning hours. Robert C. Jones, an administrator for the War and Food Administration, recognized that “living conditions in bracero camps
usually represented substandard living conditions.” Yet in supposed justification, stated that, “Although the camps offer the barest minimum of sanitary living facilities, they represent a considerable improvement in shelter and sanitary arrangements over what most of the migrants had before . . .” (Hewitt, 1982).

Also, even though sugar beet prices were at an all time high during the war, farmers kept migrant wages low. Farmers paid migrants hourly rates when weeds were thick and needed much attention but shifted to piece rates, payment by the acre, when weeds were thin (Hewitt, 1982). Working conditions also remained difficult. It was thought that the short handle hoe caused less damage to the growing plants and so although some growers switched to using long handle hoes many still required the use of the short handle hoe (Pendergraft, 1985).

Discrimination was the third, and most blatant problem migrants faced. Anglo workers from Oklahoma were believed not to be suitable for work in the beet fields and were delegated to haying. Mexicans were deemed better suited to “stoop labor.” At the same time their white counterparts were better paid. Braceros in Worland were refused service by several local businesses. In Torrington migrants were denied access to a bar next door to the police station and were subjected to segregated seating in the Wyoming Theatre. Braceros protested the treatment and attitudes displayed towards them by the state's citizens (Hewitt, 1982). In 1943, Mexico did not allow braceros to work in Texas because of the “number of cases of extreme, intolerable racial discrimination” (Hewitt, 1982). Wyoming appeared headed down the same path. At one point, Salvador Lopez Lira, representative of the Mexican
government, recommended that, if the situation in Wyoming was not remedied, that the braceros should be pulled out (Hewitt, 1982).

On the surface Wyoming made a visible effort to change the prevailing sentiments towards migrants. Mexican Independence Day (September 15) was celebrated in Sheridan and Basin. Parties were held in the migrants’ honor in agricultural communities throughout the state, but the reason for these festivities was economic not humanitarian (Hewitt, 1982). Wyoming needed migrant workers.

The original bracero program was formally terminated in 1947, and with it, came the end of the legal importation of Mexican migrants (Kirstein, 1977). Local farmers turned to contractors to bring Mexican American migrants from Texas to work the beet fields. This began a long tradition of migrant families coming from the South Texas Valley. “A boss man, generally a Mexican with a truck, would contract as much beet acreage as he could handle, then assemble and transport in a crew. The contractor would take a cut from the paid crew.” (Pendergraft, 1985).

The late 1950s and 1960s saw greater mechanization of the sugarbeet industry. Machines harvested the beets, reducing the need for manual labor. Migrants were now only needed to block, thin, and weed the crop (Holly Sugar, 1992). Also, the 1960s brought social reform throughout the US and brought a stricter policy with regard to migrant housing in Wyoming. The lack of free housing was a detriment in acquiring Mexican American migrant workers, and the beet industry again suffered labor shortages. Still, many families that had established ties with local farmers made the yearly trip and lived with farmers who provided them with housing (Pendergraft, 1985).
From this point until the present little written information exists on migrants in Wyoming. Loretta Alcaraz has seen the shifts in the annual migrations. She remembers that after the braceros stopped coming, families from Texas began coming to Wyoming. Later crew leaders brought entire families from the South Texas Valley to work the fields. As time passed, along with these families, came lone family heads leaving the family behind in Texas. Today, she feels that, although families from the South Texas Valley constitute the majority of the migrant workers in the Basin, many more single males are seen working under contractors.

Migrants in Wyoming Today

The most recent study on the migrant population in Wyoming was released in 1997 by Alice C. Larson, PhD. Larson and colleagues completed a “Review of the Migrant Worker and Dependent Population in Northwest Wyoming.” The goal of the study was to “assess future conditions for the continued presence of a target population who would be in need of health care services.”

In order to review the migrant population, Larson first identified the characteristics of the seasonal laborers in the Basin.

- Migrant workers, traveling in family groups, have historically provided Wyoming’s seasonal labor needs. Many return year after year to work for the same employers.

- In the past when there was a great deal of work available, migrants were in the area from March through October. Their presence was obvious in health and social service, education and assistance programs; as well as in temporary housing, at local grocery stores and in other frequented sites.

- Workers began thinning and weeding sugar beets on arrival, then stayed to work in beans and returned to sugar beets as needed. Many remained to help transport
harvested beets and work in the sugar plants. Other families left when it was time for their children to return to school.

- The traditional payment system is to contract with a group of workers for tasks on a specific tract of land, calculated at so much per acre. Although employers expect the work to be performed quickly, the actual hours of labor are up to the employee. Wages have not changed dramatically in recent years.

According to Esperanza Flores, former JTPA worker and Antonio Florian, former migrant worker, migrants can expect to earn $35-$55 per acre for thinning and $20-$25 dollars for weeding, depending on how weedy the fields are. Generally the sum comes to around $75 for the two stages. Sometimes during the weeding migrants are paid by the hour as an incentive to do a better job. This hourly wage averages around $5.50.

Improved technology and techniques over the past decade have again reduced the need for migrant labor in the sugarbeet fields. New techniques in “space planting” have greatly reduced the need for thinning and have made blocking completely unnecessary. Beets are now purposefully planted at 5.5 to 6.5 inch intervals instead of being broadly spread 2.5 to 3.5 inches apart. Also, improved herbicides reduce the need for hand labor. Researchers at the University of Wyoming are trying to develop a herbicide resistant strain of sugar beets so that herbicides applied to sugarbeet crops will kill only weeds (Larson, 1997).

Technical and technological advances are shortening the working season, as well. Migrants now generally arrive by the second Sunday in May and complete the weeding by the beginning of July (six weeks). Some stay and work the bean harvest, then they aid in transporting. Since there is less work, some migrants move to Colorado, Montana and Utah between jobs in Wyoming (Larson, 1997). Other
families move on to the Midwest, into Michigan and Ohio to pick berries or do other agricultural jobs, later in the summer (Powell Tribune, 1976).

Larson’s study shows that there has been, “a dramatic decrease in the local labor population from ten years or even five years previous.” So, the fieldwork performed is now almost all done by migrants. These migrants still mostly come from south of Eagle Pass, Texas, (South Texas Valley) but others come from California, Georgia and New Mexico. Also, Kickapoo Indians still come each year to work in Washakie County (Larson, 1997).

Larson estimates the population of migrant workers and dependents to be between 1,762 – 2,368. These numbers are expected to decrease though, and all “grower-related sources” believe that a major goal of the sugarbeet industry is, “to greatly reduce the need for hand labor.” Several factors, other than new techniques and technology, responsible for bringing this change are: greater production costs, government regulatory requirements, concern over labor shortages and work-related legal entanglements with migrants (Larson, 1997). Most growers do not see a change in needs for migrant labor in the next couple of years, but by 2005 or 2010 manual labor needs should be minimal. The primary researcher of sugarbeets for the University of Wyoming believes that in 10 years “65% of production will require no labor while the remaining 35% will take longer to change.” A sugar beet association president stated that, “work may be reduced, but there will always be a need for hand labor” (Larson, 1997).

These changes make the migrant lifestyle in Wyoming more difficult. With fewer migrants to serve, fewer services will be provided for the remaining migrants.
Two service providers interviewed by Larson see a time when their services will no longer be needed. Larson recognizes the problems migrants may face. "As the migrant population decreases, services such as Migrant Education, Migrant Head Start, job training and other assistance may be unavailable. Similarly, if fewer Spanish-speaking migrants are in the area, bilingual aid currently available in other services such as public health and welfare offices may be eliminated. Migrants who do come to the area may face real difficulty in fulfilling their assistance needs" (Larson 1997).

On top of financial problems, migrants still face discrimination in Wyoming. Esperanza Flores related several instances of discrimination that occurred this summer in the Basin. In the grocery stores checkers often make rude comments to migrants who utilize food stamps. One day, migrant families were told to shut up and were not allowed to use the bathroom in the NOWCAP (Northwest Community Action Programs of Wyoming) office, an office that offers services to migrants. In the DPASS (Department of Public Assistance Services) office migrants were treated like children and were actively insulted.

Migrants have played an important, if seemingly inconspicuous, role in the history of the Basin. Faced with continued discrimination, less work, and fewer public services provided, migrants may find work in the Basin economically unfeasible. This realization may come in 20 or maybe even 50 years, but when it does a colorful and determined part of Wyoming’s history will be gone.
Migrant Culture

"The constant relocating, never staying in one place long enough to establish roots, and the hard, manual labor that they face is nearly unbearable. But this lifestyle has been followed for many years by many people" (Valle, 1994).

The niche Mexican-American migrant farmworkers found and filled has existed for years. Finnish, Italian, German, Polish, Russian, Japanese, Chinese, Hindus, Filipinos, and other nationalities have had roles in the history of migrant labor in the United States (Johnston, 1985). As President Truman's Commission on Migratory Labor stated in 1951, "No large group of migrants has remained permanently migratory" (Johnston, 1985). This has proven true for migrant workers of Anglo origin, but today's migrant streams are dominated by those of color. Today, the migrant population consists of African Americans, Mexican Americans, Mexicans, Puerto Ricans, Haitians, American Indians, and Southeast Asians (Meister, 1991).

Of all the different racial and ethnic groups represented, the largest is Hispanic (Crawford, 1994). Also, this group of workers has a rich history in migrant work. These two factors have, over time, created a culture that is unique, the Mexican American migrant culture.

This uniqueness is mandated by the lifestyle lived by these "modern industrial nomads." (Crawford, 1994). The KEEP REAL cultural model adapted by anthropology professor Murphy Fox, explores these nomads. Kinship, Environment, Economics, Politics, Religion, Education, Associations, and Leisure, are the components of a functioning culture. To understand these aspects, time must be spent with a people for a significant amount of time to understand its intricacies and
nuances. Isabel Valle, free-lance writer, lived with a migrant family for 12 months. She observed, learned, and lived the migrant culture. She then compiled a book entitled, “Fields of Toil: A Migrant Family’s Journey.”

Valle lived with the Martinez family, a typical migrant family from the South Texas Valley. Valle’s case study serves well to look at the migrants in the Bighorn Basin because the majority of migrants in Wyoming come in family groups from the South Texas Valley (Larson, 1997).

Raul and Maria Elena Martinez travel to Washington State every year taking the younger of 13 children. Large families are traditional in the patriarchal migrant culture as more children equals more workers equals more money. For migrants the family is central; nothing takes precedence over family. This attitude is mandated by the lifestyle because the constant traveling does not leave time or space to establish close ties outside of kin. Many migrants travel with or have ties to extended families, which have dropped out of the migrant lifestyle and settled in regions where they found work throughout the US (Valle, 1994). In my work as an outreach worker we, at one house, registered 11 people. At that house we were told of several other outpocketings of relatives. Their house served as the social hub for relatives who came yearly from the South Texas Valley to work in the Basin. “Migrant farm work is normally multigenerational, following a family history of working in the fields and often returning to the same locations each year” (Bechtel, Shepherd, Rogers, 1995).

The environment a migrant family lives in is ever changing, making a “stable” lifestyle difficult. Migrants working in Wyoming typically reside and work in the state from May until August and return to southern Texas where they live the

Migrants work in the fields of “el betabel,” the sugarbeet. They understand the crop, knowing when and how the different stages of fieldwork must be done in order to insure a bountiful crop. Before the advent of space planting, migrants began before May with “el deshaije.” “El deshaije,” is blocking. The second stage is called “la limpieza,” or the cleaning. “La limpieza” is the thinning. This stage begins in May. The third stage is, “el tiron,” the pulling. “El tiron” consists of just this, going up and down the rows pulling or cutting the larger weeds missed during “la limpieza.” It generally takes much less time depending on how good a job was done during “la limpieza” (Flores, phone interview). Finally, some migrants stay until late fall aiding in the trucking of the beets to the sugar mills (Larson, 1997). Throughout this process migrants face many occupational hazards.

Agriculture is a dangerous working environment, the second most dangerous occupation in the United States (GAO, 1992). Major hazards migrants face in the fields are: chemical exposure from fertilizers and herbicides and a lack of healthy working conditions, meaning a lack of bathroom facilities and sufficient, clean drinking water (Valle, 1994). In 1987, F.R. Olveda of Powell, Wyoming, brought the situation of the migrant to the attention of former Senator, Al Simpson. Simpson agreed that toilet facilities should be provided to beet laborers in the fields. The two
also talked of other issues, and Olveda believed the quality of housing provided also deserved attention (Oudin, 1989). In 1997, one migrant worker was hospitalized for three days in Intensive Care due to herbicide exposure. Some migrants came to the clinic with dermatological problems caused by chemicals applied to the fields. Others experienced back problems due to the stoop labor. Still others complained of loss of feeling and tingling in their forearms and hands due to hoeing. Several acquired bursitis in their shoulders. But despite these conditions migrants return yearly to earn money to live on during the winter.

During winter Texas migrants often look for work but are for the most part unsuccessful; a majority live on summer earnings. Rene O. Oliveira, a democrat from Brownsville in the Rio Grand Valley (South Texas Valley) stated, “The Rio Grande Valley is one of the most depressed areas in the country. And the reasons are because of natural disasters... and inadequate responses from Washington” (Valle, 93). These economic woes in their home state necessitate the yearly trip to Wyoming.

The economic situation for migrants is bleak and is the biggest problem migrant workers face. Migrant workers are chronically unemployed. Roughly half have annual incomes below the US poverty level. Half earn less than $7,500 a year despite a high prevalence of farmworker families with multiple wage earners (National Advisory Council on Migrant Health, 1993). Migrants generally work, at the most, for minimum wage, and in some cases much less.

In Wyoming most of the work is not paid for on an hourly scale but on a “piece” scale, or by the acre. A normal wage per acre (18 rows) in hoeing the beet fields is about $35-$55 an acre during “la limpieza” but can be as low as $30 (Flores,
phone interview). This salary system can result in earning less than minimum wage. Conditions vary from field to field. In some fields the piece scale system functions justly allowing migrants to earn a livable wage. In other cases where weeds are particularly thick or large, the time it takes to do the job correctly increases. The wage does not. Oftentimes migrant workers will not go into the fields if they don’t believe it is worth their time. In this system time is of the essence. Workers sometimes do not want to go to the doctor, enroll in the health program, or even walk a quarter-mile to use the port-a-potty because it will take 20 minutes and this takes time away from working and money away from the family (Meister, 1991).

In the Basin though, many migrants are looked upon as lazy and undeserving of money from federal programs. Francis Hecker, former director of the migrant school in Lovell has heard many complaints about migrants. “Some people resented the fact that federal money was being spent on the migrant worker. And they felt it was not fair.” Others asked, “Why should we help these people?” (Ontiveroz, 1987). But Hecker is quick to point out that the migrant laborers earn about 2 million dollars over the course of the summer and about 52% of this is pumped back into the local economy. He adds that payments from migrant schools, health care programs day care and other sources put about another $300,000 dollars into the community. Hecker continues saying, “These figures would indicate that the migrants are indeed a viable work force and contribute heavily to the local economy. Because the migrants are here for just a short period of time, their contribution to the area economics is never fully appreciated.” (Ontiveroz, 1987).
The life of a migrant is hard, and for this reason, migrants believe in working hard. Nothing comes easy to a migrant family and to scratch out a living there is no time to be lazy. There are plenty of days when there is no work to be had and when work avails itself it must be taken advantage of through long days and working efficiently. This ethic is demanded, because as Raul Martinez put it, “We may not earn money every day, but we do spend it every day” (Valle, 1994). As the head of the family in a patriarchal culture, Raul Martinez decides what is best for his family. He works hard to insure they lead a good life. But the wife of a migrant worker also leads a difficult life. A migrant mother must be up before dawn to cook breakfast and prepare a lunch. Usually she works in the field, and at the end of a long day she cooks dinner. Migrant workers have their families and they have their work. Migrants take a lot of pride in these two things. They are a poor, yet proud people.

For these reasons migrants struggle with necessities most Wyoming residents take for granted. Putting food on the table becomes a priority not a given. Many migrants utilize food stamps. Some look for assistance through local agencies like local food banks but are often turned away because they are not “from the community.” And, “if we give it to one family they will tell all the family and friends and soon we will be giving away all the food to the migrants.” I worked in the same building as the food bank and heard these types of comments. Gasoline to get to and from the fields has to be considered, and money must be tucked away for the return to life in Texas. Emergencies cannot be planned for financially. Car repairs and medical emergencies can be devastating economically for migrants.
Many migrant workers come to Wyoming in the spring with just enough money to make the trip and upon arrival are almost broke. The migrants are referred to NOWCAP (Northwest Community Action Programs of Wyoming Inc.) NOWCAP runs the federal Job Training Partnership Act Program (JTPA) for migrants and seasonal farm workers. Through this program migrant workers can obtain funds for "unmet needs" upon arrival. These needs can range from car repairs to help in paying the first month's rent. Also, the JTPA helps migrants find work in the fields, obtain their GED and aids them in finding and training for jobs outside of agriculture (JTPA, 1998). Because migrants are in Wyoming for only four months out of the year, few take advantage of the job training in the area (Flores, phone interview).

Economics plays a direct role in shaping the migrants' home environment. Most migrant families have homes in Texas. These homes are the products of years of toil and labor in the fields. They, for the most part, are self-constructed by family and friends knowing the favor will be returned. The process of creating a home can take years. One year the land is bought, and perhaps the next year there is sufficient money to pour the foundation. The next year the walls go up. The next year there's not enough money to do anything, and so it goes until a home is created (Valle, 1994).

In Wyoming migrants have several housing options. In some instances migrants have family that have established themselves permanently in the area and in these cases may stay with family. Some migrants return annually to the same farmer and having established a solid working relationship, the farmer will provide housing in the form of a trailer home, guest house, or a house on his property fallen into
disuse. In these instances rent may or may not be charged. A third option for migrants is renting apartments of houses in the communities where they work. According to Esperanza Flores, former employee for JTPA, rental costs in the Basin for migrant families can vary from $300 to $500 per month. In one case this summer, a family of migrants was charged $800 a month solely due to the lack of housing now available to migrants. These individuals were reported to the proper authorities for taking advantage of migrant workers, and the situation was remedied (Flores, 1998).

These housing conditions for the most part are notably better than “migrant housing,” where migrants are provided shacks or sometimes tents. These migrant outposts are generally cramped and unsanitary despite the efforts of the Occupational Safety and Health Act to better the living conditions for migrants (Valle, 1994).

Along with the costs of rent come costs of furnishing the new residence. A good place for migrants to find furniture is yardsales. To keep costs down migrants furnish sparingly. A central table, several chairs, a couch or two, beds, maybe, and a TV are their material goods. Laura Lockard, outreach worker for the Wyoming Migrant Health Program, described one apartment seen during outreach as “just a table and some chairs and these blankets spread out all over the floor where they slept.”

Frugality is demanded by the migrant lifestyle and is seen in the migrant’s sense of politics. Politics here is used a base sense and consists of a migrant family’s beliefs and attitudes towards life. Migrants worry about putting food on the table, not electing presidents. The politics they center on deal with family and work negotiations. In regard to wages and working conditions, they believe they deserve
just treatment and in many cases have to argue with employers to obtain this. The only true political power a migrant worker holds lies in farmworker unions.

The harvest of fruits and vegetables is a timely affair that in many cases must occur within a several week period making the industry vulnerable to strike. As Cesar Chavez said, “The boycott is our strength.” Chavez, legendary Latino farmworker activist, rallied farmworkers to “La Causa,” (The Cause) to improve working conditions and wages in the 1960s (Valle, 1994). His work brought the migrant and seasonal farmworker plight to the forefront and did bring about substantial change for a time. Yet, today farmworkers still are excluded from federal protections for labor organizing. Due to the transient nature of the worker and an oversupply of workers, agribusiness has changed little with respect to the labor conditions migrant farm workers face (Rothenberg, 1998).

Roman Catholicism is the predominant religion in the migrant culture. The Spanish brought Catholicism to Mexico in 1521. During their reign over Mexico the religion permeated the country. There are still many indigenous cultural beliefs and practices that influence people’s daily lives. Despite the fact that Catholicism is the predominant faith, folklore plays a prominent role in migrant lives. A cup of “hierba buena” or “manzanilla” tea is often preferred over a trip to the doctor. Some illnesses such as “mal puesto” or “ojo,” the Evil Eye, require different remedies. A broken egg set in a saucer under the victim’s bed may “lump together” as the fever brought on by “ojo” abates. “Curanderos,” special healers, use special powers to heal mental problems such as “susto.” “Susto” is “a mental state brought on by some shock or misfortune” (Valle, 1997).
President Truman’s Commission on Migratory Labor reported in 1951 that “No large group of immigrants has remained permanently migratory. This probably is the best evidence that people are not migrants by choice.” (Johnston, 1985).

Migrant families rarely speak of their work in terms of endearment. Instead of complaining, they voice a hope for their children. “We all like to study and we want out children to study as well. We believe in education, and it’s very important for our children. Do you think we like this kind of work for our children? We don’t. But when there is nothing else, what can you do?” said Maria Elena (Valle, 1994).

Sentiments like this were expressed daily in the clinic this summer.

Migrant Head Start, located in several communities in the Basin provides a needed boost for the education of migrant children ages birth to school entry age. “Migrant children are provided learning environments and experiences enabling them to solve problems, initiate activities, explore, question, and gain mastery through learning by doing.” Almost as important, the migrant children are kept out of the fields and away from the dangers that accompany them. This measure of protection is furthered by nutritional, medical, dental and mental health programs for the children (Migrant Head Start).

In tandem the migrant school program works with school-age children. The migrant school is federally funded and is designed to give migrant children a chance to continue their education. Migrant children learn the basics, as in a regular school. The students’ progress is kept on permanent record in a computer bank in Little Rock, Arkansas. Francis Hecker, former director of the migrant school in Lovell, said that the first year the school opened some migrants had difficulty speaking
English, but most of today's students have a good grasp on reading, writing, spelling and mathematics. Also, Hecker said that 20 years ago it was not uncommon to see a few teenagers attending migrant school but today few are older than 12. Most pre-teenagers are already helping their families in the field (Ontiveroz, 1987). In Worland this past summer, the migrant school also had a preschool to care for infants and babies so as to keep them out of the fields.

Another program which aids migrants is WIC (Women, Infants and Children). This federally funded program helps mothers raise healthy children. It provides funds to aid in buying healthy foods, especially dairy products, for the children.

Still, the main problem facing all migrant programs is a lack of federal money. In the summer of 1998 both Migrant Head Start and the Migrant School opened in early June, yet were closed in early July due to lack of funding.

Receiving a decent high school education is difficult for migrant students, both academically and socially. Many migrant students work in the fields before and after school. They are too exhausted to keep up with their studies. Students may attend high school in as many as three or four schools in a year. The constant change of the learning environment contributes to a lack of success for migrant students (Valle, 1994). "Migrant children are usually two or more years below grade level in reading and mathematics skills, and the dropout rate for migrant students is 45 percent, much higher than the 29 percent rate for the general population" (GAO, 1992). One program designed specifically for migrants to continue on with a higher education is the College Assistance Migrant Program (CAMP). This program is funded by the US Department of Education, the state of Texas, and St. Edward's
University in Austin. Qualifying migrant students are aided in defraying the cost of the first year of college. Fifty-eight percent of the 1900 students who have participated in CAMP have finished their college degrees (Valle, 1994). It is a consensus among migrants that education is the way out. In an economically depressed area, education sometimes is not enough.

In terms of associations, or the relationships one develops outside of kin, the migrant maintains very few. The trend in the US leans towards more dependence on associations and less on kin. The migrant culture, in its transience has only one true constant, family. Families are often isolated due to working and living arrangements. Valle points out three rules for the migrant lifestyle: “Never make plans. Always be ready to move. Adjust.” These unwritten rules require a certain amount of aloofness so as not to establish close ties with anyone or anything. If ties are made the ensuing pain from breaking them becomes disheartening. But the migrant culture is social and families enjoy getting together to discuss family, work and problems. Migrants understand each other’s situations and are friendly and kind-hearted. One migrant family, new to the Basin this summer, had a particularly difficult time finding work and housing. Migrant families familiar with the area helped them out until they found work and an apartment. Sharing is a necessity. Families remember times when they had nothing and someone helped them out (Valle, 1994).

Leisure is one aspect of life of which migrants see little due to financial constraints. But this does not mean to say that they don’t know how to have a good time. Around Powell, migrant families often get together to have a party. The family hosting the party will buy a sheep or lamb to roast. Outside the men will roast the
animal over an open fire while the women prepare tortillas, rice, beans, tamales, etc. The entire evening usually costs around $50 (Florian, Kathy, phone interview). These parties give migrants a chance to break away from the familial isolation. The men have a chance to talk about work, plans for the fall and oftentimes car troubles. Migrant women have a chance to share recipes and talk about family, especially the children (Valle, 1994). Also Tejano, or Tex-Mex music will be playing in the background. This is the music of the migrants, "Texan of Mexican descent." (Valle, 1994). Since money is scarce, shopping at the mall, school athletics, and going to the movies or a dance may be out of the question. Migrants still find ways of entertaining themselves at home with friends or relatives (Valle, 1994). Migrants may not have much money but they get the most out of it and try to get the most out of life. Loretta Alcaraz describes the migrants as always seeming happy, always having a smile on their face no matter what problems they face.

History of Migrant Health

"The eventual goal should be to give as many migrants as possible roots in a community where they can have a sense of belonging and where they can become eligible for any services offered by the community to other citizens." (Johnston, 1985)

In looking at the distinct perspectives of migrant culture a clearer picture of an under-served population is formed: family-oriented, poor, transient, proud, Catholic, undereducated, isolated, yet possessing an ability to enjoy life. Each aspect of culture has a distinct affect on the migrants' health but two in particular make good health difficult for migrants: poverty and transience. "Poverty is not unique to migrant
farmworkers, but, combined with migrancy, results in a degree of substandard living conditions that have been described as 'third world'" (Meister, 1991).

For well over a century migrant workers have suffered through difficult working and living conditions leading to poor health. Occasional reports on the difficult lives of migrants emerged as early as the 1940s and by the 1960s the plight of the migrants gained national recognition (GAO, 1992). Valle cites one of Maria Elena’s vivid memories. “I remember when we first got there I looked around and I said, ‘Look at all those chicken coops!’ Then the farmer told us that that was where we were living. It was dirty. There were a few portable toilets for quite a lot of people and they were always filled to the top. I knew I was going to get sick.”

In 1964 a list of common problems for migrants and their families was developed. Children were most often plagued by: respiratory and ear infections, communicable diseases, impetigo and other skin conditions, parasitic infestations, diarrheal disease, nutritional problems and accidental injuries including poisoning. The adults were victims of respiratory infections, tooth decay, muscular aches and pains, ‘stomach upsets,’ cardiovascular conditions, genitourinary infections, and other conditions ranging from nutrition problems and pregnancy to tuberculosis (Johnston, 1985). These problems, for the most part, arose from the difficult working and living conditions migrants face (Butt, 1991).

For these reasons, in combination with the growing social justice movement in the 1960s, the Migrant Health Act was passed in 1962. Before this Act, migrant health was either ignored or funds were granted solely to conduct physical examinations of workers brought to the US under the bracero program and Public
Laws 78. In the 1940s and early 1950s Public Health Service (PHS) divisions made suggested state standards for migrant labor camps and looked into the cause for poor migrant health. In addition to these activities PHS also provided block grants to the states for general public health, yet no money was specifically set aside for migrant health care (Johnston, 1985).

In 1952 an Inter-Bureau Committee of the PHS was appointed by the Surgeon General to determine the role the PHS should take in regard to migrant health. The committee developed some basic guidelines to providing migrants with health care:

- "The eventual goal should be to give as many migrants as possible roots in a community where they can have a sense of belonging and where they can become eligible for any services offered by the community to other citizens." (Johnston, 1985).

- "Services should be developed, 'in a way that will integrate them into, rather than separate them from the rest of the population.'" (Johnston, 1985).

- "Continuity of services as migrants travel from one place to another should be recognized." (Johnston, 1985).

In 1954 the East Coast Migrant Conference was held "to develop ways to extend health, education and welfare services to agricultural migrants and their families through interstate and interagency cooperation" (Johnston, 1985). In response to the 1954 conference, the Surgeon General established a Migrant Health Unit (MHU) within the PHS. The MHU, though, accomplished little medically, but was a key in initiating an understanding of the demographics of the migrant population (Johnston 1985).

By the 1960s there was no question that migrant health care needed to be addressed. Senator Harrison Williams, chairman of the Senate Subcommittee on Migrant Labor, introduced a simple and concise proposal "allowing for a great deal of
flexibility in order to fit widely varying situations, and focusing on the provision of medical care, since that was the need most keenly felt by migrants.” (Johnston, 1985).

On September 25, 1962, the bill was passed in both the Senate and House without a problem and was signed by President John F. Kennedy (Johnston, 1985).

The Original Migrant Health Act was written as follows.

Grants for Family Health Service Clinics for Domestic Agricultural Migratory Workers

Sec. 310. There are hereby authorized to be appropriated for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General

(1) to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of

(i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishing and operating of such clinics, and

(ii) special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, and

(2) to encourage and cooperate in programs for the purpose of improving the health conditions of domestic agricultural migratory workers and their families.

(Johnston, 1985).

It was simple and idealistic, yet good for its time. This revolutionary piece of legislation recognized migrants, for the first time, as valuable members of our society.

The program was modified and improved through provisions. The program’s merit was re-evaluated every three years. Each time the program was reevaluated, it was deemed very worthwhile, but the provisions of the act, economically speaking, were never enough.
New factors were and are constantly discovered that must be considered in the migrant equation. Over the years spending was increased yet did not match the increasing rates of inflation. Necessary hospital care was added to the services provided. Under the 1970 amendment act, eligibility was extended to seasonal farmworkers and their families. Project planning and the development, acquisition and modernization of buildings were added to the service list. The population eligible for services was defined in detail, and health education and social services were added. By 1984, the program had established 300 sites for health care services to migrants and had been instrumental in immunizing migrants against communicable disease. Still, few major strides were taken in view of general health improvement (Johnston, 1985).

In spite of additions, both monetarily and service based, the MHP fell short of its original lofty goals. There was a time when the goal of the MHP was to “raise the health status of migrants to that of the general population” (Johnston, 1985). The ever-increasing cost of medical care made apportioned dollars, although empirically more, provide fewer and less adequate services. Johnston writes, “To expect a minimally funded program to meet all the health needs of a deprived population in a time of high and rising cost is to expect the impossible, especially when it is recognized that the population served is not fixed but fluid, constantly drawing off at the top those best able to maintain themselves in a community and drawing in at the bottom the most deprived and educationally handicapped.”
Migrant Health Today

The same problems that plagued migrants 34 years ago, still plague migrants and their families today. Migrant health problems still cover a broad range: accidents, pesticide-related illness, musculoskeletal and soft-tissue problems, dermatitis, non-infectious respiratory conditions, reproductive health problems, health problems of farmworker children in the fields, climate-related illness, communicable disease, urinary tract infections and kidney disorders, and eye and ear problems. In addition, there are general health problems, such as malnutrition, poor dental health, obesity, cardiovascular disease, diabetes mellitus, anemia, and mental disorders (Mobed, Gold, Schenker, 1992). (Italics added to indicate similarities between the 1964 list, and present list of problems.)

The italicized items demonstrate a lack of fundamental improvement in migrant health care over the past 30 years. During a 1990 visit to a labor camp in Florida, Secretary of Labor Elizabeth Dole, was “shocked” by the conditions she witnessed. “What she saw was typical of labor camps as well as privately available migrant housing throughout the country. Such housing is sub-standard on every count. It lacks insulation; there is often no indoor plumbing, no running water, no heat, no electricity” (Meister, 1991).

Migrant health problems, when looked at quantitatively, further show the disparity between migrant health and middle-American health. An enlightening array of statistics have been compiled on migrant health. Some statistics on migrant health are sometimes inferred from “indirect and incomplete but suggestive data,” (Meister, 1985) but the statistics presented here are standard, seen in many journal articles on
migrant health. They represent a few of the many but give the reader a solid idea of the plethora of health problems that migrants face.

Recent studies done by the University of Texas Health Science Center show the average life expectancy of a migrant worker is 48 years (Valle, 1994). This statistic places migrants in the same life expectancy range as people in India, Indonesia, Burma and Sudan (Butt, 1991). Infant mortality rates in the migrant population are 25 times higher than the national average (Sandhaus, 1998). Deaths from influenza, pneumonia, and tuberculosis are also 25% higher (Butt, 1991). The rate of parasitic infection in the migrant population is 11-59 times higher than in the general population (Sandhaus, 1998). Diabetes mellitus is 3 times more prevalent in the Mexican American population but 5 times more prevalent in the Mexican American migrant population (Butt, 1991). Migrants count among the most poorly nourished group of people in the US according to a 1990 study by Public Voice for Food and Health Policy (Valle, 1994).

Statistics are easy to peruse; occasionally interest is raised. In comparing the general and specific statistics regarding migrant health, inferences must be made and an overall realization of the under-served condition of the migrants' health must be drawn.

In 1989, a comprehensive study of migrant health was done by G.E. Alan Dever, Ph.D., from Mercer University School of Medicine. The study was done in conjunction with the Migrant Clinician Network and the National Migrant Resource Program. In his research Dever looks “to determine if the patterns displayed in the home-base areas are representative of the migrant population specifically or just the
Hispanic South Texas population." Dever compared his two study area counties, Cameron and Willacy, both located in the South Texas Valley, with two control counties from the same region. The control group was used to see if the migrant population health problems varied from a strictly Hispanic non-migrant population. The control group was similar to the study area counties, both socially and economically.

The following criteria were used to match study and control counties:

- 1. > 50% Hispanic
- 2. >70% of households with income of < $7,500
- 3. >25% of population < 15 years of age
- 4. Median age range =/− 4 years
- 5. Similar socioeconomic status

The results are seen in the following graph.

![Graph showing diagnostic groups for study and control counties.](image-url)
These results strongly indicate that the Mexican-American migrant farmworkers have unique health problems that pertain specifically to their lifestyle and not solely to their economic or ethnic status. It illustrates that they suffer from health problems that extend above and beyond those health problems associated solely with poverty.

These results obtained by Dever are important to this study for another important reason. The migrant farmworkers studied were home-based in the South Texas Valley in the counties of Cameron and Willacy. The migrants that come yearly to the Basin are also from the South Texas Valley.

In an all age comparison done by Dever of the top three reasons males and females visited Migrant Health Clinics the following results were obtained.

**Males**

- 1. Health supervision of infant/child
- 2. Otitis media
- 3. Diabetes

**Females**

- 1. Diabetes
- 2. Pregnancy
- 3. Health supervision of infant/child

**Wyoming Migrant Health Statistics**

The Wyoming Migrant Health Program has existed in Wyoming for 25 years. For the majority of these years the program was operated by NOWCAP. In 1997
NOWCAP lost the competitive block grant for migrant health to the Wyoming Reproductive Health Council. With the loss of the grant NOWCAP no longer was maintained health statistics on migrants. Therefore no health statistics could be obtained for migrants in Wyoming prior to 1997.

Wendy Young Basse, outreach worker for the Wyoming Migrant Health Program in 1997, compiled a report entitled “Baseline Information and Statistics for the Big Horn Basin for the 1997 Migrant Health Program.” Statistics were calculated for each county in the Basin: Park, Big Horn, Fremont, and Washakie. Washakie County statistics are used in looking at migrants’ health in the Basin.

In 1997 the Migrant Health Program enrolled 213 families in the program totalling 840 migrant and seasonal farmworkers and their families. Of this 840, 47% were enrolled in Park County, 33% in Washakie County, 15% in Big Horn County and 6% in Fremont County.

In Washakie County 53 migrant and seasonal farmworker families were registered, 273 individuals. Washakie County had the largest families, averaging 5.3 individuals. The Migrant Health Program served them through a voucher system in which medical providers served the migrants’ health needs for monetary vouchers,
which in turn were reimbursed by the Migrant Health Program. The majority of the migrants received two or less vouchers for medical treatment. By family, 28% did not need any medical assistance from the program. 27% of the families used 1-2 vouchers, 27% used 3-4, and 22% used 5 or more vouchers.

One hundred and thirty-seven vouchers were used throughout the summer. Fifty-five percent went to doctors, 35% to pharmacies, 5% to dentists, 3% to hospitals, and 2% to optometrists.

A comparison for medical need was done by age. Infants born after 1996 accounted for 12% of vouchers given. Toddlers ages 1 to 2, accounted for 24%. Children ages 3 to 11, accounted for 12%. Together, all children born after 1986
accounted for 48% of vouchers given. Youths ages 12 to 17 and seniors (over 60) accounted for the age groups receiving the least amount of vouchers, 4% and 1% respectively. The remaining 46% of the vouchers doled out were for adults.

These results correspond well with the study done by Dever that shows the top three reasons why males and females visit migrant health clinics. With children and infants accounting for almost half of all vouchers it can be assumed that 1 major reason that both males and females go to clinics in the Basin is their children. Although the health statistics for the summer of 1998 have not been calculated, as an outreach worker I can confidently state that one of the main reasons both adult males and females came to our clinics was to check for and to keep tabs on high blood sugar levels associated with diabetes. This also aligns with Dever’s findings. And, although we saw few pregnant women, the pregnant women seen, used many vouchers for prenatal care.

The health care migrants receive in Wyoming is greatly enhanced by the Wyoming Migrant Health Program and it is through this program that knowledge is
gained about migrants' health in Wyoming. This program is in place because the problems that faced migrants 30 years ago still face migrants in Wyoming today.

**Wyoming Migrant Health Program**

In April 1997 the Wyoming Reproductive Health Council (WRHC) was informed that it had been awarded the Migrant Health Center competitive block grant for the state of Wyoming. The objective of this grant is "To support the development and operation of migrant health centers and projects which provide primary health care services, supplemental health services and environmental health services which are accessible to migrant and seasonal agricultural farmworkers and their families as they move and work." (WRHC, 1997).

With this in mind the WRHC ushered in a new phase in the Wyoming Migrant Health Program (WMHP). "The WMHP is a federally funded program that pays for basic health services for migrant and seasonal farmworkers and their families. ... The program conducts health screenings for migrants and seasonal farmworkers and their families and provides basic health care through mid-level providers. A network of doctors, dentists and pharmacists will also provide services when needed and be reimbursed by the program. **It does not pay for hospitalization or for many types of specialists**" (WRHC pamphlet, 1998).

The program, as it states, is for migrants and seasonal farmworkers (MSFWs) and their families. Migrant farmworkers as defined by the WMHP are, "farmworkers... who move from place to place to do farmwork," where as, "seasonal farmworkers are based locally but do not work a full year in farming." To be eligible their principle source of income must come from farmwork. Also eligible are persons
who under these same stipulations were formerly migrants or seasonal farmworkers during the past two years. Another important factor of the program is that "immigration status is not a consideration in determining eligibility or providing services" (WRHC pamphlet, 1998).

The program is designed with certain goals in mind to serve migrants, mostly Latinos, who:

- Face language and cultural barriers to using health services
- Have no health insurance
- Are not eligible for Medicaid
- Sometimes delay getting care until an injury or illness is so severe that a visit to the Hospital Emergency Room is required (WRHC pamphlet, 1998).

For these reasons, migrants often obtain medical bills that they cannot pay. Many times medical costs are covered by local health care providers who are not reimbursed. In this way the program aids local health care providers and MSFWs. Local employers also benefit from having healthy laborers.

To accomplish what needed to be done for the migrants, the Executive Director of the WRHC, Julie Lehman, immediately sought training in the administration of the Migrant Health Grant and cultural sensitivity. The WRHC hired two graduate students, one soon-to-be nurse practitioner and one in Sociology, to develop medical protocols and administrative policies (WRHC, 1997).

Migrants arrive in May and since notification of receiving the grant arrived in April of 1997, a plan of action for the MHP had to be developed rapidly. But, with the constraints considered, "priority was given in terms of program administration to those actions which would be most beneficial to farmworkers" (WRHC, 1997).
Outreach workers were hired to canvas the basin region to inform MSFWs of the changes in the health services to be provided. Outreach workers, in pairs, canvassed work sites, homes, campgrounds, laundromats, churches, grocery stores, and yard sales to find, inform and enroll migrants and seasonal farmworkers in the MHP. The Program Director, Dan Christopulos, found medical providers (doctors, dentists, and pharmacists) who would provide services to farmworkers without cultural barriers. This, in combination with the development of a voucher system, allowed medical referrals to occur immediately. The WMHP created and distributed brochures and posters in Spanish to get the word out and a 1-800 number was established for migrants and medical providers with questions (WRHC, 1997).

The first summer the WMHP was more or less thrown together but the dedication and caring of outreach workers and concerned providers helped it to be successful. By the summer of 1998, after a year of learning experience, the core professionals of the MHP, Executive Director Julie Lehman, Project Director Dan Christopolous, and Medical Director Kathy DeSanto had designed an improved system for providing health care for migrants; yet they followed the same basic structure as in 1997.

Between the summers of 1997 and 1998 the WMHP worked hard to find nurse practitioners, mid-level providers, willing to work in migrant clinics. In 1997 all medical problems, from a simple ear infection, to a pregnancy check-up were vouchered to doctors. It was not a cost-effective system. An analysis of services provided in 1997 showed that the majority of all doctor visits dealt with basic health care. These are problems a nurse practitioner (NP) can readily handle. The idea was
to contract NPs to work in established migrant health clinics where they would be able to treat all basic health care problems and refer more serious medical situations to MHP providers (doctors or dentists). Since NPs were contracted for less money than doctors, the savings would be used to provide further services to migrants (WRHC, 1998).

In addition to finding NPs for the program, clinics were established in four communities in the Basin. In Worland, clinics were held for MSFWs in the Washakie County Public Health Family Planning Services building, Thursday and Friday from 12:00 - 8:00 PM. Susan Hester, a licensed NP, came up for 2 days from her home in Lander to provide her services. In Powell, clinics were held in the Park County Public Health, at the Powell Annex, Tuesdays and Thursdays from 1:00 - 8:00 PM. The Medical Director, Kathy DeSanto, finishing her practicum as a nurse practitioner, worked under the direction of Dr. Darcy Turner from Thermopolis, to provide services. The Greybull clinic was held every Thursday from 4:00 - 8:00 PM in the Bighorn County Public Health building. Nurse Practitioner Mary Freund, a NP in Lovell, worked this clinic as well as the clinic in Lovell. The Lovell clinic subsequently was closed in June due to a lack of use by migrants. The NPs and Dr. Darcy Turner traveled great distances to work these clinics. Finding caring and knowledgeable professionals willing to travel great distances to provide services to migrants was one of the biggest problems the Wyoming Migrant Health Program faced.

The WMHP developed new ideas to better itself in the off-season. The WMHP designed two health fairs in Worland and Powell to enroll and screen
migrants. The health fairs show creativity in providing health care. They were held in the evenings, just like the clinics, so that the migrants would not have to miss work to attend. Local businesses were contacted to donate food and refreshments. A package of household accessories, toothbrushes and toothpaste, and a key chain with the National Migrant Health Hotline number attached were given to those who completed enrollment and screening. As a final incentive to get migrants to come, a local Tejano band was hired to play for a couple of hours after the screening. Entrance was free for attendants of the health fair. Creative measures like these help reach the migrants scattered throughout this vast agricultural region.

The WMHP designed health surveys to be used in the clinics in both Spanish and English for children, adolescents and adults. A record of patients' health history is important for health care providers. They need to understand health problems of the past to make accurate diagnoses of current health problems. In tandem, permanent health records were developed for individuals, so that a health history will be available in Wyoming for migrants who return annually.

As a measure to provide health care without creating cultural barriers, a Cultural Sensitivity Training Workshop was held in May to coincide with the return of the migrants. The workshop provided all interested individuals associated with migrants, in one way or another, an opportunity to better their understanding of migrant culture and to use this knowledge to provide services in a respectful manner.

Small details were learned. It is not acceptable for a male outreach worker to hug a migrant man's wife unless the wife initiates the hugging. It also is ill advised for a male outreach worker to visit a migrant family at their home when there is a
possibility that only the woman of the family and children are home. The migrant
culture is patriarchal and protective of family. To individuals steeped in Anglo-
American culture this may seem ridiculous, but small cultural infractions such as
these can mean the difference between a family coming to the health clinics or
staying away. In the social migrant culture, word of mouth advertising is the best
advertising possible. Poor advertising can turn off an entire migrant community.

On a broader scale, the Workshop taught translation skills that place emphasis
on the provider/patient relationship and not the translator/patient relationship. It is
very important that migrants see the provider as a person, a friend who is willing to
help and not just a machine to provide health care.

As May drew near, the WMHP hired outreach workers to be in the migrant
community as it arrived. Five outreach workers were hired, myself included. The
outreach position is of special importance to the migrant health program because
these individuals are the delicate link between the migrants and medical services. An
offensive outreach worker can turn off migrants to a great migrant health program.
An outreach worker must be compassionate, communicative, and have dedication to
the job. All five outreach workers hired were bilingual, but more importantly, were
committed to serving the migrant population. Mitch Garcia, Cultural Sensitivity
Trainer, said he would much rather have an outreach worker who could not speak
Spanish but who truly cared for migrants than one who was bilingual, but showed a
sense of disdain towards migrants. The migrant health program did a great job of
finding a team of outreach workers that worked well with each other and the
migrants.
The outreach workers were based out of Worland and Powell. Outreach workers went to the migrants to get the word out about the clinics' locations and services provided by the WMHP. Outreach workers enrolled migrants, did intake of patients at clinics and translated between providers and patients when necessary. Other duties included working the 1-800 line and following up on patients as requested by the NPs. Additionally, Kathy Florian, an outreach worker and wife of a former migrant, was instrumental in creating a list of national and local agencies that provide services to migrants.

For one to see how migrant health is truly provided and to understand how the components of the WMHP function on a day-to-day basis a day in the WMHP is illustrated.

A Day in the Wyoming Migrant Health Program

At 8:00 AM Kathy Florian is in the office at the Annex Building in Powell. She must be there to tend the 1-800 line. Since the phone doesn't ring that often, a lot of her time is spent reviewing files to see who needs follow-up. Also, she calls various local and national agencies to seek financial support for migrants whose medical needs have gone above and beyond what the WMHP can provide and who find themselves with large medical bills. When Dan Christopulos, the program director, comes into the office he and Kathy review files that she feels need follow-up. As the project director he must OK her decision. One might ask why the program director doesn't make these decisions. The program director is the overseer. The outreach workers know the patients and their cases personally from working in
the clinic and have been told by the NP or the provider that follow-up will be necessary.

At 11:00, Lida Sanford, a Colombian-born outreach worker and I arrive at the office. We do any paperwork that we may need to take care of, but usually we just gather up the list Kathy has made for us of families, individuals that need to be contacted, and various other tasks that need to be done. List in hand, we set out to do outreach work.

Today we have to make sure that all of our posters advertising the clinic are still posted. We make the rounds at the grocery stores, laundromats, post office, McDonalds, etc., anywhere migrant families frequent. This accomplished we decide to make a circuit of the sugar beet fields. We drive the lanes, running east/west and the roads, running north/south, that dissect the agricultural area. We try to cover as much ground as efficiently as possible, using binoculars to aid us in our search for migrant workers. We travel west towards Cody, then double back heading east towards Lovell. Some days our search leads us south to Emblem, Frannie, Otto, or as far as Greybull. When we locate migrants working in the fields we stop and talk. Many times we come upon the same families and just make sure they are doing all right. We talk about the family, work and the weather.

When a family or group of workers is found that are not registered in our program, we explain to them what the WMHP is, what services it can and can’t provide, where the clinics can be found, and show them the 1-800 number where they can contact us. We give them an informative brochure in Spanish or English that contains all the information that we tell them. Secondly, we know that for every
minute not spent working, money is lost. We ask for their local address so that we can pass by in the evening to register the family in the program. This accomplished, we are on our way.

By now it is usually getting late in the afternoon, so after a bite to eat, we start our local rounds. Since migrants are, at best, difficult to locate in the fields, follow-up must be done in the evenings, at their homes. About 5:30 migrant families start to arrive home from a hard day in the fields. The families we need to visit are few and far between. Some families are scattered on surrounding farms while others rent apartments in Powell and nearby Byron and Lovell. The distance to be covered, in combination with a limited number of hours in the evening to work, can make follow-up difficult.

Difficult as it can sometimes be, outreach work is rewarding. Household visits are made to addresses collected in the fields to register families. Families are always happy to know they have a place to turn for health needs. Also, the migrants are always grateful that you have taken the time to track them down and remind them that they (or a child) need to return to the clinic or that they have a doctor's appointment coming up. Many follow-up visits are to see why individuals failed to keep a doctor or dentist appointment. Migrants cite a lack of time as the primary reason. Others include a lack of transportation because the family vehicle was in the field. In some cases they say that the problem went away.

One cultural problem that confounds migrant health programs is the inherent mistrust migrants have in modern medicine. Some migrants believe, “I will get well if God wishes it.” Others have a cultural reluctance to place individual medical needs
over the needs of the family. Also, many migrants place faith in and use folk remedies. Migrant males especially avoid seeking medical care due to machismo (AHCPR, 1998). For these cultural reasons, tracking migrants down to make sure they seek proper medical attention takes a lot of time.

Another aspect of follow-up that takes a lot of time is socializing. As outreach workers, working in an extremely social culture, hanging out with the family and talking about nothing in particular is a necessity. Invariably, a soda is offered or a tamale or a tortilla and to reject this show of good will is an insult. It silently says that the family is poor and doesn’t have enough money to offer anything. It is an insult no matter how politely it is done. Besides, as an outreach worker, it is a great way to get a taste of the culture. The problem is finding a balance between the proper and necessary amount of socializing and overall time management.

In Worland there is a clinic from 12:00-8:00 PM. Laura Lockard, a 23 year old outreach worker from Gambier, Ohio, and Javier Muro, a 23 year old outreach worker and Worland native, arrive at the clinic at about 11:30 to make sure all is in order. Susan Hester, a NP from Lander, arrives a little before twelve and the clinic is ready for business.

Usually several migrant families will be waiting at the door by noon. Many times the entire family comes due to vehicular constraints, but most often, only one or two family members see the nurse practitioner. Individuals seeing the NP must be first registered in the program. If already registered, they must fill out a health history survey and then they must sign a voucher for each service provided. Today,
the first client to see Susan is a woman. She seems hesitant in wanting to tell Javier what exactly her problem is as he fills out a voucher for her to see the NP.

For this reason outreach teams consist of both a male and a female. This combination is important for an outreach team. There are times when having a female translator is a key in allowing women to feel comfortable in coming to the clinic. Likewise, males often prefer a male translator. This set-up is also beneficial in the field. When talking with a family in the field, it is almost culturally mandated that the male outreach worker talk with the head of the family while the female talks with the mother.

Returning to the clinic, our female patient, after signing the voucher, enters the exam room with Laura to see Susan. It is quickly discovered through a series of questions that she has a urinary tract infection. Susan provides a prescription for the correct antibiotics. Another voucher, with a twenty-dollar stipend, is signed and can be taken to a pharmacist associated with the WMHP to have the prescription filled. For the services provided, the client pays a five-dollar co-payment.

The voucher system is widely used in MHPs across the United States. The voucher system allows a MHP to provide professional services that by itself, it would not be able to provide. Vouchers are granted for doctor appointments, prescriptions, eye appointments, dental services, lab work, and some specialist services (WRHC, 1998). In Wyoming, providers connected with the WMHP sign a memorandum of understanding, which states that they will provide services for standard Medicaid rates. The voucher system is also valuable because since one must be filled out for every service provided, a strong statistical record of WMHP uses is established.
As the day proceeds, things slow in the clinic after the initial rush. About 6:00 though, other migrants, after putting in a long day’s work, begin to filter into the clinic. The first patient is a male who says he was once diagnosed with diabetes. After filling out the necessary paperwork, he enters the exam room with Javier. Looking over his health history survey and checking his blood sugar levels, Susan easily determines that yes, he does have diabetes. His blood sugar levels are far too high. Through a long series of questions and answers, made longer by translation, Susan sees the problem being exacerbated by diet. She explains to the man how and what he should eat to lower his blood sugar levels and talks about the possibility of medicating. Also, she feels the man needs to check his blood sugar daily to insure it does not reach dangerous levels and to monitor his progress in lowering it. He cannot come into the clinic everyday due to time constraints. A glucometer is needed. The problem though, is that a glucometer and the necessary strips cost over $100. The most money Susan, by the guidelines, can provide for the glucometer would be $20, since it must be bought at the pharmacy. But, there is no way the client can spend over $80 to obtain one. In these instances, which occur fairly often, Dan, the Program Director or Julie, the Executive Director, must be called and permission obtained to voucher out the needed funds for the glucometer. Javier calls Dan and Dan gives him permission to voucher for the glucometer. As the evening winds down records are filed, notes are taken on who needs follow-up, and by 8:00 PM another day in the WMHP is completed.

Close tabs must be kept on the WMHP budget. As a general rule, $65 can be allotted for a doctor appointment, $75 for a dentist appointment, the first $45 of eye
care, $20 per prescription, and up to $100 for specialists (WRHC, 1998). While the majority of all services provided are aptly covered by the stipends, some greatly exceed these limits. Major surgeries, Emergency Room visits, major dental work and pregnancies are situations the WMHP is unable to handle due to budget constraints.

The Budget of the WMHP for expenditures for the fiscal year 1998-1999 would be apportioned as follows.

### MIGRANT HEALTH

**APRIL 1, 1998 THROUGH MARCH 31, 1999**

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**BUDGET JUSTIFICATION**
Looking at the budget total, $127,165.00 seems sufficient to cover any health care problems that migrants might face during their four-month stay in Wyoming. But, what is overlooked is the fact that administratively the program runs year round and provides services to seasonal farmworkers on a year round basis. As an outreach worker I was always questioning why we had such limited funds for providing services. I, as do many others, often fail to take into account the cost of running a federal program. Of the entire budget, the total amount of money allocated specifically to medical services comes to $53,200, less than half of the total budget. $53,200 in terms of today’s rising medical costs is not enough to take care of every need. “The WMHP is a federally funded program that pays for basic health services.” It cannot pay for expensive medical procedures. That would deny other migrants basic health care. Current estimates show that migrant clinics are able to serve less than twenty percent of this nation’s migrant farmworkers (Dever, 1991). The WMHP is a good program, but it simply cannot do it all.

Who can the migrant turn to in Wyoming when health problems turn from basic to serious, life-threatening ones. Services must be provided, but who will pay? Over the course of the summer several instances like this arose. Kathy Florian, working with Project Director Dan Christopulos, was instrumental in securing payments in most cases through various local and national agencies.

But these funds cannot be relied upon. No one can count on the fact that a charitable organization will defray the medical costs incurred. It is for this reason that migrants do not take their children to see a doctor until a problem seems life
threatening. One pregnant migrant woman left the state returning home due to economic fear. These individuals are hard workers who come to the state of Wyoming to aid local growers in raising a bountiful crop. Yet when these same workers encounter true health trouble in our state we turn our backs. We say there is nothing we can do. But maybe there is a way to help.

**Migrants and Medicaid in Wyoming**

Medicaid provides vital health care coverage to many disadvantaged Americans today. It covers low-income families and provides services to low-income elderly and disabled people. It is the nation’s single largest publicly funded program that provides health care coverage to these groups (Feder and others, 1992). This being the case, many Americans, like migrant workers, slip through the cracks. Many poor Americans fail to qualify for Medicaid due to eligibility requirements yet at the same time they cannot afford private insurance. Many Americans qualify for Medicaid yet they may not apply because they are unaware of their eligibility. Also, the application process is time consuming and tedious. Applications can be hard to understand, especially so for non-native English speakers. “Newly eligible populations without historical links to the welfare system are particularly at risk” (Feder and others, 1992). Compounded, these factors greatly diminish the possibility of Mexican American migrant farm workers and their families from receiving Medicaid benefits.

Medicaid was enacted along with Medicare in 1965 under Title XIX of the Social Security Act. It was created “to pay for health care for recipients of welfare assistance and certain other needy people.” The program is funded in partnership by
the federal and state governments. The federal government provides matching funds to states for the services provided (Feder and others, 1992). The basic services provided by Medicaid are "physician and hospital services, laboratory and x-ray services, nursing facility services for persons over 21, prenatal care, and EPSDT for children" (Feder and others, 1992).

But what determines if a migrant worker is eligible for these services? "Medicaid is a program of federal requirements and state choices" (Feder and others, 1992). The Federal Code of Regulations (CFR) for Medicaid determines what groups of people and benefits the states must cover in order to obtain matching funds. Within these standards though, the states are given a certain amount of leeway and can broaden or restrict to some extent the groups covered and services provided as long as they meet the basic guidelines of the CFR.

One can begin to see that being poor does not necessarily mean that one will qualify for Medicaid. In Wyoming Medicaid covers children between the ages of 6 and 16 in families living at 100% of the Federal Poverty Level (FPL). Pregnant Women and children under six years old qualify at up to 133% of the FPL (Wyoming Medical Assistance Manual, 1998). "More than half of the poor fail to qualify for program assistance" (Feder and others, 1992). The limitations of the program are due to financial constraints. The US does not have a universal health care plan. This limits whose health it can feasibly cover. These decisions are made through an eligibility process that includes categorical or non-financial requirements and income and asset requirements (Feder and others, 1992).
Categorical requirements usually include being aged, blind, disabled or a member of a single parent family with dependent children (Feder and others, 1992). In Wyoming, however, residency is the main non-financial requirement holding back migrant workers from possible Medicaid qualification.

Since Wyoming falls under region VIII of the Department of Health and Human Resources, I looked at how each state in the region handles the migrant worker’s situation. The states in region VIII are Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming (Migrant Health Center Referral Directory, 1998). I received the residency requirements from each state and found all to be very similar, with the exception of Montana. A simple illustration is seen in the concise response I received from Gayleen Henderson, Medicaid Program Specialist from Utah.

Dear Mr. Sanders

Thank you for your inquiry about residence requirements in the state of Utah. Our Medicaid policy states that to be eligible for Utah Medicaid, a person must be a resident of Utah. However, there is no requirement that the person have a permanent residence or fixed address. Policy also states that an applicant who gives up residency in another state to become a Utah resident can receive a medical card from Utah even though a card was issued by the other state in the month the person applies in Utah. There also is no requirement that they have to have been residing in Utah for any length of time before we can consider them to be a Utah resident.

The way this policy is being applied to the Migrant worker population is that when they come to Utah to work, they have two choices, they can establish residence in Utah, or they may claim another state as his/her state of residence. We have a question on our application form asking if the person intends to make their home in Utah. If they answer “Yes”, we would consider them to be a Utah resident. If they say “No”, we would not consider them to be a Utah resident.

Sincerely

Gayleen Henderson, Medicaid Program Specialist
The obvious question of importance is that of the intention to make a home in Utah. The Wyoming application asks, “Do you intend to reside in Wyoming?” But this leads one to ask, “What is a home?” “What does reside mean?” The inherent ambiguities of this defining question give the individual states and individual caseworkers liberty to choose if they want migrants to qualify for Medicaid or not. In one case a migrant may qualify by stating that, yes, they do have a home in Wyoming, for the time being. In another case this answer may be rejected because the worker plans to return to Texas in the fall.

This summer, while working for the Wyoming Migrant Health Program, this point of ambiguity became a point of animosity. We believed migrants should qualify for Medicaid, but workers at the Department of Family Services (DFS) believed they did not qualify due to residential reasons. This point of ambiguity allows personal prejudice to thwart the possible providing of needed services to migrant workers. One DFS worker openly expressed prejudicial sentiments against migrant workers stating, “They are scamming the system.” This quote sticks with me although other similar comments were made. And these comments were not overheard. They were made directly to me, another outreach worker, and the program director, Dan Christopulos. This prejudice was so blatant that Dan felt compelled to file a letter of complaint with the regional manager of the DFS.

All the questions that arose out of this incident centered on the question of residency. The following is a letter sent by Julie Lehman, Executive Director of the WMHP, to the Regional Manager of the DFS.
Dear Mr. [Omitted],

Please accept this correspondence in response to the copy of the letter sent to you by Dan Christopulos dated June 29, 1998. The documentation that Dan has included in that letter is what he stated to me over the telephone.

I am especially concerned about the statement; “A client who expressed intent to reside in another state is not a Wyoming resident”. I do not believe that that is the legal definition of a Wyoming resident, but on Monday I will contact our Council attorney and request clarification. I will also request a copy of the court decision in the Oregon Court Case (to which Dan refers) from the University of Wyoming School of Law.

[Paragraph pertinent to employee in question and the actual incident has been omitted by this writer. This letter is intended for use by Dallas Sanders to support his thesis paper and not intended to be used in any other manner nor is it available for publication without this writer’s consent. JL]

On July 15 and 16, 1998, a federal site assessment team will be visiting the Powell site. I am very concerned that we hasten to resolve this issue at your level before anything is said to the team by the outreach workers. We would welcome the opportunity to assist in providing cultural competency and sensitivity training to any staff members that you feel could benefit from this endeavor. In addition, is it possible to audit and reevaluate those migrant and seasonal farm workers who have sought assistance and been denied, based upon this residency statement?

Please let me know how we can be of assistance. Your attention to this matter is truly appreciated.

Sincerely,

Julie Lehman  
Executive Director

For reasons of personal privacy, I was unable to access the actual letter written by Dan Christopulos to the Regional Manager of the DFS. But the references Julie Lehman makes in her letter referring to cultural competency and sensitivity training gives one reason to believe that prejudice may be interfering with proper work practices.
By the end of the summer migrants in Powell had full access to the Medicaid application process but no formal change in policy was made. For this reason, individual migrant cases were handled differently in different communities in the Basin.

In a separate incident in the Greybull clinic, a pregnant migrant worker, whom we had referred to the DFS office, told us that a woman in the office told her that she should go back to Texas to have her baby. This is unacceptable. When I called the DFS office to see if this was truly the case, they denied it. It is for these reasons that The Wyoming State Medicaid Policy needs clarification on this specific point.

Section 6005.02 under the Wyoming Manual for Medical Assistance Programs deals with residence as a non-financial eligibility requirement.

**6005.02 Residence (42 CFR 435.403)**

To be considered a Wyoming resident, a client must meet the following requirements:

A. The client must reside in Wyoming on a permanent and voluntary basis and will not be denied solely because he/she is homeless.

B. A client who moves to Wyoming may be considered a resident so long as he/she is not receiving public assistance in another state, except a client can receive Medicaid in Wyoming even if he/she has received Medicaid in another state that month as long as the reason for the dual issuance is administrative (such as the time frames for case closure) and not dual residence.

C. A client who resides in a Wyoming medical institution is considered a resident so long as the client intends to reside in Wyoming on a permanent and voluntary basis.

D. If a child in DFS custody is placed in an out-of-state facility or a IV-E eligible child moves from another state to Wyoming, residence is met.

E. A Wyoming resident who is residing in another state on a temporary basis (such as a student or someone who is temporarily
assigned out-of-state through employment) is considered to remain a resident.

F. A client who expresses intent to reside in another state is not a Wyoming resident.

Under these conditions migrants most certainly do not qualify for Medicaid in the State of Wyoming. Thus, they do not even make it past the preliminary stage of categorical requirements.

One obtains a different perspective though, in looking at the guidelines for state residence set forth in the State Medicaid Manual, a manual issued by the Health Care Finance Administration, a branch of the Department of Health and Human Services. This manual is published to aid states in complying with the federal Medicaid guidelines, the CFR.

Section 3230 in the State Medicaid Manual under Guidelines for State Residence, defines state residence.

Guidelines—

3230. State Residence. A state’s Medicaid program must provide Medicaid to eligible residents of the state, including residents who are absent from the state. The conditions under which payment for services is provided to out-of-state residents are set forth in 42 CFR 431.52, 535.403(a), and 436.403(a).

So far, no major changes are noted. The CFR references given above do not touch upon services being provided to migrant workers, out-of-state residents. But, continuing on to section 3230.3 an important discovery is made under Specific Prohibitions and Exceptions.

3230.3 Specific Prohibitions and Exceptions.—Factors which must be taken into account when determining state of residence are variables such as age, institutional status and ability to express intent. These factors were included in the state residence regulations to avoid problems such as state durational
residences requirements by a state in the absences of a compelling governmental interest. *(Shapiro v Thompson, 394 U.S. 618 (1969))* When determining state of residence the following prohibitions and exceptions must always be considered by the state in conjunction with the conditions in 3230, D through 3230.2 or the criteria as specified in an interstate agreement under 3230.4.

What is important to note is that these “prohibitions and exceptions must always be considered by the state.” Continuing, part B under exceptions states:

**B. Exceptions.—**When one of the following exists, it supersedes the general residency rules set forth in 3230.1—3230.2. When more than one exception exist, the agency may decide which exception takes priority.

The specific exception pertaining to migrant workers states:

* An individual involved in work of a transient nature or who goes to another state seeking employment has two choices: The individual can establish residence in the state in which he/she is employed or seeking employment, or the individual may wish to claim one particular state as his/her domicile or state of residence, provided he/she satisfies the rules set forth in this section.

Example 1: A migrant worker who resides in state A enters the migrant stream in state A and returns to state A every year. He may choose to retain state A as his residence or may change his state of residence as he goes from state to state.

This documentation, sent to me by the National Health Law Program, clearly illuminates that the migrant worker must be treated as a special case with regard to residency requirements for Medicaid eligibility. The migrant worker in Wyoming cannot be turned away simply because of owning a permanent residence in the South Texas Valley. It is that simple.

**Recommendations**

To clarify, Wyoming must clearly state the aforementioned exception and example that supersedes general residence requirements as listed in the State Medicaid Manual. The state of Montana has already made this change.
FMA 302-1

Department of Public Health
And Human Services

SECTION:
NONFINANCIAL REQUIREMENTS

FAMILIES ACHIEVING
INDEPENDENCE IN MONTANA

SUBJECT:
Residence

Supersedes: 304-1, 10/01/97

References: 42 CFR 435.403; 45 CFR 233.40; ARM 46.10.107,.302

GENERAL RULE – Applicants and participants must be residents of the state. The minor child must reside in a family setting maintained or in the process of being established by the caretaker relative as home.

RESIDENCY

Residency is established when an individual is:

1. Living in Montana voluntarily with the intention of making a home here and not for a temporary purpose. A child is a resident of the state in which the custodial caretaker relative is a resident. Residence does not depend upon the reason for which the individual entered the state, except it may indicate whether he/she is here voluntarily or for a temporary purpose; OR

2. Living in Montana, is not receiving benefits from another state, furnishes a written declaration of intent to reside in Montana permanently, has a job commitment or is seeking employment in the state of Montana.

Temporary residence with no intent to remain within the state does not fulfill the residency requirements except in the case of migrant workers or other persons who qualify as residents under the second definition of residency above.

Janet Ludwig, social worker for the Montana Legal Services Association, informed me that this change in policy was carried out in September of 1998, in order to comply with the guidelines of the State Medicaid Manual. This change in policy grants migrants in Montana the possibility of financially qualifying for Medicaid.
Now Wyoming has a chance to make a significant contribution to the migrant population, a population that lives here yearly, if only for four months at a time. Wyoming has a chance to make Medicaid more accessible to migrant farm workers. It is difficult enough for migrants to lead the lifestyle they do and to overcome cultural and language barriers to live and work in our state. Wyoming must make the right choice.

Wyoming is the "Equality State." In December 1869, Wyoming Territory granted women the right to vote and hold elected office, the first state to do so. The legislation was passed with little debate or fanfare during the first legislature of the territory. Suffragists working for this right for women in the East were rather surprised when the Wyoming Territory passed this revolutionary measure (Larson, 1977).

Once again Wyoming has an opportunity to enact a somewhat revolutionary measure. The state can facilitate the Medicaid application for migrant workers. Wyoming can show its appreciation and support for its migrant workers by following the example set by Montana, and more importantly by following the guidelines outlined in the State Medicaid Manual.

In Wyoming, Medicaid is extended only to pregnant women, children under 16, and senior Medicare beneficiaries. Pregnant women and children under 6 qualify at up to 133% of the poverty level and children between 6 and 16 qualify at 100% of the poverty level (State Medical Assistance Manual, 1998). Forty-eight percent of the vouchers in Washakie County were granted to children by the WMHP in 1997. Also, many vouchers are given to pregnant mothers to help with prenatal visits. The
WMHP health statistics indicate that extending Medicaid to migrants would definitely aid them. I believe though, that extending Medicaid to qualifying migrants would stretch this budget at the most by around $150,000. When taking into account the fact that migrants pump almost $1,500,000 into the local economies in the Basin, it is evident that they are putting more into the state than they would be taking away (Ontiveroz, 1987). Medicaid is a joint federal and state program. The taxes migrant workers pay both nationally and while they are here in Wyoming contribute to Medicaid’s funding. They deserve access, at the very least, to see if they are eligible financially for the Medicaid program in Wyoming.

Other reasons for enacting a change in policy can be seen in the Wyoming Constitution. Section 2 of the Declaration of Rights in the Wyoming State Constitution states:

Equality of all. – In their inherent right to life, liberty and the pursuit of happiness, all members of the human race are equal. (Keiter, Newcomb, 1993).

This portion of the Wyoming State Constitution closely mimics the Declaration of Rights found in the Declaration of Independence.

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their creator with certain inalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.

The similarity in these federal and state declarations is not coincidental. Both the state of Wyoming and the United States government feel that life, liberty and the pursuit of happiness are fundamental rights given to all citizens. Herein lies the problem. Migrant workers, citizens of the United States, do not have these same rights in the state of Wyoming. Although migrant workers reside in this state for up
to four months out of the year contributing to both cultural and economic gains, their access to these inalienable rights is diminished in our state.

Section 3 of the Declaration of Rights in the Wyoming State Constitution speaks of Equal Political Rights.

Since equality in the enjoyment of natural and civil rights is only made sure through political equality, the laws of this state affecting the political rights and privileges of its citizens shall be without distinction of race, color, sex or any circumstance or condition whatsoever other than individual competency, or individual unworthiness duly ascertained by a competent jurisdiction. (Keiter, Newcomb, 1993).

The incident which occurred with the DFS this summer clearly shows that migrant workers are discriminated against by a distinction of race, color, or both. The current wording of the Wyoming Medicaid policy allows this prejudice to continue. It is obvious that personal prejudice cannot be wiped away, but with a more succinct definition of who qualifies under non-financial requirements this personal prejudice can be kept outside of the Medicaid application process.

Article VII, section 20, of the Wyoming State Constitution speaks of the duty of the legislature to protect and promote the health and morality of the people.

As the health and morality of the people are essential to their well being, and to the peace and permanence of the state, it shall be the duty of the legislature to protect and promote these vital interests by such measures for the encouragement of temperance and virtue, and such restrictions upon vice and immorality of every sort, as are deemed necessary to the public welfare. (Keiter, Newcomb, 1993).

The state constitution outlines protecting and promoting health and morality by the means of virtue. Virtue is "moral excellence or goodness." Is it morally excellent to turn away a pregnant migrant worker from the Medicaid application process based on residency? The migrant workers live and work in Wyoming and
during this time their health and moral well being must be important to the state of Wyoming. They provide an invaluable service that year-round citizens of these communities will not perform. For this contribution to our economy alone, they deserve the full respect of the people of Wyoming and the rights that come with respect. These rights must be granted so that migrant workers have the access to Medicaid that is equal to that of other laborers throughout the state.

The question of the migrant worker goes beyond and above policy and law and in transcending both returns to the notion of humanity. The question of human dignity and worth is raised. Should it make a difference in health care if a person gets sick in Wyoming or Texas? No. The person is still sick and must be treated, not because he or she is a resident of a particular state but because he or she is a human being. Opening the Medicaid application process to the migrant workers acknowledges the migrant workers as valued human beings in our Wyoming society.

In looking at the question of human dignity and worth, the migrant question enters a new realm, that of justice. Improved social justice is the only way for migrants to improve their socio-economic status and in turn improve their health. William P. DeVeaux looks at the migrant situation in his doctoral thesis entitled: Migrant Farm Workers: A Study Based on Gibson Winter’s Concept of Responsible Society. DeVeaux examines migrants and their position in society. He views their position as second class and rightly so. He examines why this is, but more importantly illuminates how migrants should be treated from a Christian ethical stance.
When the problem of migrant farm workers is examined in the light of Christian ethics, certain issues surface as being crucial. First, the condition of migrants is that of outcasts in the American social system. They are not considered as being an integral part of the society. The migrant is exploited and little has been done to end this type of exploitation. Therefore, the Christian ethicist must first declare in the midst of the society that the treatment of migrants is at odds with the Christian principles of justice and righteousness. After taking this step, the ethicist must then become involved in social policy matters. It is these affairs which will provide a better share of the nation's goods and privileges for his brother, the migrant. (DeVeaux, 1979).

Yet DeVeaux understands the reality of the situation.

A notion of justice provides a standard by which present efforts for a just society can be measured. The contemporary ethicist is aware that this goal is not completely attainable. However, this realization does not diminish the need for the continuing effort for justice in society. (DeVeaux, 1979).

Wyoming must look at the migrant worker from three possible angles: legal, economical and ethical. Wyoming is a predominantly Christian state yet its treatment of migrant workers with respect to Medicaid is not ethical. Yes, Wyoming will save some Medicaid money if migrants are not served, and migrants will still come to Wyoming. But is this right? Also, migrant workers pay taxes both in Wyoming and nationally. They pay for Medicaid as members of the public and they deserve public access. Wyoming must choose ethics over economics if necessary, so at least migrants have a chance to qualify financially for Medicaid based on economic not residential status. In making this decision, Wyoming must remember what is outlined by the State Medicaid Manual, it's own Constitution, and the Declaration of Independence.

In taking all three angles into account, I believe Wyoming must make a change in its residency policy with regard to the non-financial requirements of Medicaid eligibility. Others involved in the field of health care defend this action.
The National Advisory Council on Migrant Health “advocates universal health coverage for laborers and their families with Medicaid coverage transferable from state to state” (Sandhaus, 1998). Also, the Committee on Community Health Services of the American Academy of Pediatrics recommends improved health care for children of farmworker families. They “exhort” pediatricians to “Recommend the full inclusion of all farmworkers' children, regardless of parental residency or citizenship status, for all state Medicaid and indigent health care programs and any federal health care legislation reform.” In taking these recommendations into account, this is how the corrected Wyoming Medicaid policy should appear.

6005.02 Residence (42 CFR 435.403)

To be considered a Wyoming resident, a client must meet the following requirements:

A. The client must reside in Wyoming on a permanent and voluntary basis and will not be denied solely because he/she is homeless.

B. A client who moves to Wyoming may be considered a resident so long as he/she is not receiving public assistance in another state, except a client can receive Medicaid in Wyoming even if he/she has received Medicaid in another state that month as long as the reason for the dual issuance is administrative (such as the time frames for case closure) and not dual residence.

C. A client who resides in a Wyoming medical institution is considered a resident so long as the client intends to reside in Wyoming on a permanent and voluntary basis.

D. If a child in DFS custody is placed in an out-of-state facility or a IV-E eligible child moves from another state to Wyoming, residence is met.

E. A Wyoming resident who is residing in another state on a temporary basis (such as a student or someone who is temporarily assigned out-of-state through employment) is considered to remain a resident.
F. A client who expresses intent to reside in another state is not a Wyoming resident.

G. An individual living in Wyoming, not receiving benefits from another state that can furnish a written declaration of intent to reside in Wyoming permanently or has a job commitment or is seeking employment in the state of Wyoming.

a. Temporary residence with no intent to remain within the state does not fulfill the residency requirements except in the case of migrant workers or other persons who qualify as residents under the second definition of residency aforementioned.

**Conclusion**

Migrants have come seasonally to work in Wyoming since the early 1900s. They leave homes behind, in search of earning a living in the sugarbeet fields. They face prejudice and difficult living and working conditions, yet still come to the Big Horn Basin every year. The Basin has long been dependent upon migrant laborers to produce a bountiful sugarbeet crop. The sugarbeet industry is one of the most profitable agricultural sectors in Wyoming, but has provided only meager wages for the Mexican American migrant farmworker.

Migrant farmworkers count among the poorest populations in the United States. Roughly half of all migrant farmworkers earn annual wages below the US poverty level. Half earn less than $7,500 a year despite a high prevalence of farmworker families with multiple wage earners (National Advisory Council on Migrant Health, 1993). In Wyoming growers pay migrants by the acre. For “la limpieza” and “el tiron” combined migrants can expect to earn $75 per acre over the course of the season. Nonetheless, many migrants still qualify for public assistance in the form of food stamps and the WIC program.
Migrants work hard under difficult conditions for the little money they make in the sugarbeet fields. Earning little money directly leads to poor living conditions. And poor living conditions in combination with difficult working conditions lead to poor health. The average life expectancy of a migrant worker is 48 (Valle, 1994). Infant mortality rates are 25% higher than the national average (Sandhaus, 1998). Also, migrants are among the most poorly nourished group of people in the US despite the fact that they harvest our fruits and vegetables (Valle, 1994).

The Wyoming Migrant Health Program helps migrants deal with their health problems while they work in the state. “The WMHP is a federally funded program that pays for basic health care services for migrant and seasonal farmworkers and their families” (WRHC Pamphlet, 1998). The majority of migrants come to the clinics in the basin with basic health care problems. Bursitis, tingling and loss of feeling in the forearms and hands, backaches, diabetes, dermatological problems, and colds are all problems normally handled by the migrant health program. Childbirth, a broken arm, and serious infant illnesses are problems that must be referred to hospitals, and the high cost of health care in hospitals poses a serious problem for migrants.

Medicaid in Wyoming is strictly reserved for residents. Residency is obtained by residing in Wyoming or by intending to reside in Wyoming. But migrant workers follow the crops residing in different states as they go. The majority of migrants in Wyoming come from the South Texas Valley to reside in Wyoming for four months out of the year to work in the sugarbeet fields. They do not intend to reside in Wyoming for twelve months out of a year. The State Medicaid Manual recognizes
the uniqueness of the migrant lifestyle and makes an exception in the residency
requirements so as not to let the migrant population slip through the cracks. The
Wyoming Department of Family Services has not acted in ways consistent with the
State Medicaid Manual. Wyoming should not ignore these requirements any longer.

Wyoming cannot continue to ignore what migrant workers have meant to the
state’s agricultural industry. Migrants work hard and are proud of their work; work
they do is difficult but honorable. Migrants help feed the people of the United States.
But when times are difficult Wyoming does little to help the migrant family.

Rolando’s family arrives in Wyoming early in May of 1999. His parents find
work thinning the beet fields of a local farmer. A week later an outreach worker for
the Wyoming Migrant Health Program finds them in the fields. She remembers them
from the summer before and asks how Rolando is doing? She asks them when they
want to register for the WMHP. She also tells them that they can apply for Medicaid
this year if they wish.

Rolando’s family does just that. They still feel the financial burden from
Rolando’s emergency surgery from the previous summer. In July while Rolando
plays outside their apartment in Powell with some friends, he falls and breaks his
arm. Luckily, Rolando qualified for Medicaid and his trip to the emergency room is
covered. When Rolando’s family returns to Texas in early August, they leave with
the feeling that they have been treated justly by the people of Wyoming.

Wyoming has a chance to make this scenario a reality. Migrants have given
much of themselves to the state of Wyoming and now Wyoming has a chance to
reciprocate. Migrants are human beings and for this reason alone deserve health care.
Wyoming must make the right choice and recognize the significant contributions migrant workers make to the agricultural economy, local infrastructure, social traditions by extending Medicaid to this important element of the workforce.
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