from the office of:
Senator HARRISON A. WILLIAMS Jr.
New Jersey
352 OLD SENATE OFFICE BUILDING - WASHINGTON 25, D. C. • CAPIJOL 4.3121 EXT. 4744 Honday P. H .0 October 19, 1964
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FOR RELEASE:
WILIIAMS SEEKS MIGRANT HEALTH ACT EXPANSION
Washington, D. C., October 19-- Senator Harrison A. Williams (D., N.J.) today called for continuation and expansion of the federal Migrant Health Act (Public Law 87-692). Williams, who was the original sponsor of the 1962 law, called attention to the continuing health needs of migratory farm workers and their families, in connection with a Public Health Service report just issued on the first full year of operations under the act.

Migrant farm families, Williams said, are among the Nation's neediest citizens. Their health needs have gone unmet in the past not only because of poverty and ignorance, but also because of their necessarily transient relationship to the communities in which they work.

The 1962 act authorized grants for migrant health projects, especially family health service clinics. Congress intended the act, Williams said, both to help the migrants themselves and also to protect others who might be endangered by occasional epidemics touched off by migrants' illnesses.
"In my judgment," Williams said, this first year's work under the act "has yielded impressive results and establishes a solid foundation for continuation and expansion of the program beyond its present expiration date of June 30, 1965. With the assistance provided under the act, State and local organizations have been enabled to provide several thousand migrant families with services such as these:
"(1) family health clinics, held at times and places where the migrants can reach them, for the treatment and prevention of illness.
"(2) sanitation services, to ald in the correction of unsafe conditions such as contaminated water supplies and inadequate waste disposal.

[^0]FROM THE OFFICE OF THE SUBCOMMITTEE ON MIGRATCRY LABOR
ROOM 4226, NEW SENTATE OFFICE BUIIDING
Senator Harrison A. Williams, Jr., Chairman

## FOR REIEASE: TUESDAY, FEBRUARY 7, 1961

Cincinatti, Ohio --- Senator Harrison A. Williams, Jr., (D., N.J.), Chairman of the Senate Subcommittee on Migratory Labor, said today that the work of the subcommittee could end within two years.
"The legislative program I will introduce within the next two weeks could, if given support and understanding by the public, deal with the most pressing problems of the present migratory worker stream. We have visited eight states and taken nearly 2000 pages of testimony to gether the facts we need to test old legislative proposals and formulate new ones.
"I feel that the individual bills have met the test of discussion and re-evaluation. We are starting off early this year with our hearings; we can hope, I believe, for legislative action in this and the next session of Congress."

The Senator made his corments in an address prepared for delivery before the Farm Labor Conference at the Shearton-Gibson Hotel. Five hundred visitors, including representatives of grower groups and church groups, were expected. Secretary of Labor Arthur J. Goldberg had addressed the group yesterday.
"Secretary Goldberg and I," said Senator Williams, "have already informally discussed the legislative program. His interest and constructive attitude lead me to believe that the Subcomittee and the Department will work together harmoniously ior mutual objectives. In fact, the present Administration is already dedicated to a policy of interest and humanitarian action on the migratory worker issue. Hence, I feel that the rate of progress will be accelerated this year."

The Senator also said that he hopes the Subcommittee will contribute to the development of a long-range program which would ultimately lead to a ntabilization of the farm worker labor force in the face of growing mechanieation and dwindling number of workers on the farms of the nation.

The Senator also said, "The prediction for the next ten years points to a steadily decreasing farm labor force with an equally dramatic rise in the skills required by the agricultural worker. These signs point up the fact that we can no longer look to conditions prevailing under present and past agricultural employment.

Mechanization to an even greater extent than we now have is obviously ahead. Unless we have some plan to encourage development of a skilled work force, we will be faced with a set of new problems before we can possibly cope with them. The fact is, however, that we do not have such a program although all of the necessary state and federal agencies for such an effort are already in existence.
"Federal legislation could, therefore, conceivably help us frame one. We could, for instance, direct the Secretary of Labor to conduct a positive program of recruitment of damestic workers.
"The Secretary would initiate the recruitment in domestic supply areas, arrange for transportation to reception centers located at points convenient to the demand areas and provide subsistence and neeessary expenses to the workers while in transit, subject to atandards developed by the Secretary covering transportation, feeding and medical care.
"At the reception centers workers would be available to employers by an agreement between employers and workers, guaranteed by the Government, providing for prevailing wage payment, employment guarantees of not less than three quarters of normal working time and that housing, subsistence and transportation furnished by the employer shall meet the standards necessary for health and safety.
"The employer and worker would exercise a free selection of job opportunities and workers. The terms of the agreement would be worked out at the reception center pretty much as they are now between employers and workers. Return transportation would be guaranteed the worker completing his term of employment.
"The employer would pay a service charge -- $\$ 15$ or so -- per worker for transportation and subsistence furnished from point of recruitment to the reception center. After the selection of workers the employer would assume the obligation of providing transportation, housing and other prerequisites provided for in the agreement.
"In short, the Federal Government, in cooperation with state agencies would guarantee the performance of the employer with respect to the agreement while on the other hand, it would relieve the employer of his remaining obligations if the worker failed to complete his contract.
"Present users of foreign labor would not assume any adaltional financial burden by the recruitment of domestic workers under this program. On the other hand, this type of recruitment program will attract the more experienced;
reliable and efficient workers which of course bas been one of the major concerns of employers regarding the use of domestic workers.
"The same careful selection and placement could be applied in a national program. If we find that a positive recruitment program -- together with guaranteed protective features of the overall program -- does not yield the number of domestic workers needed, I see no reason why supplementary foreign workers should not be added to whatever extent may be necessary.
"We are importing foreign workers on a permanent basis to meet some of our needs because no positive efforts have been made to attract qualified domestic workers. In other instances workers are available in some rural areas where depressed conditions exist because of inadequate employment opportunitites. These workers can be given appropriate training with the assistance of such agencies as the state extension service.
"We might consider the inclusion of appropriate training programs with the guarantee of an employment opportunity upon completion of the prescribed course of training. Agricultural employers would have the assurance that workers were qualified and interested in employment by the successful com pletion of such training courses."

The Senator briefly described the bills he will introduce this year:

1. Education Bills for Children and Adult Migrants: Two such bills, introduced last spring, were favorably reported from the Education Subcommittee in the Senate Committee on Labor and Public Welfare. The bills would provide federal funds for areas particularly affected by seasonal demands for instruction for youngsters in the migratory worker stream. Programs for adults would offer courses in fundamental edncation and practical training in the use of sanitary and other modern fecilities.
2. Crew Leader Registration: Two bills were introduced in the BightySixth Congress. The final bill released last year from the Subcommittee to the Full Committee on Labor and Public Welfare combined features of both This year's bill would establish a licensing system to curb those relatively few labor contractors who make work arrangmenets between worker and farmer and, in so doing, sometimes cheat both the grower and laborer.
3. Minimum Wage: The Subcommittee will revise the proposals offered last year. The new bill will again propose graduated yearly increments, but it will also contain provisions to preserve the piece-rate system.
4. Child Labor: Last year's bill sought a 16-year-old minimum age. The Subcommittee is now preparing a bill which may change that age, follow-
ing the suggestions of those witnesses who suggested that a lower age may not be harmful to youngsters.
5. Migrant Housing: A housing bill introduced last year provided guaranteed and low interest direct loans to encourage official agencies and private non-profit groups to offer satisfactory housing for farm workers. A revised bill will be introduced this year. It will contain additional provisions to cover housing for the migrant who wishes to become a homeowner and also for the worker who may spend the entire year on one farm.
6. Child Welfare and Health: Amendments to the child welfare laws to provide for day-care centers and other services for migrant children and to the public health service laws to provide better health programs for migrant families. In addition, special appropriations for both of these items will be proposed.
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# Senator HARrISON A. WILLIAMS Jr. 

NEW JERSEY
352 O1d Senate Office Building . Washington, D.C. 20510 . 225-4744
FOR RELEASE:
SUNDAY, DECEMBER 24
67-82
MILLION AMERICANS EXCLUDED FROM HEALTH CARE
WASHINGTON, December 24 -- U. S. Senator Harrison A. Williams, Jr., (D-NJ) said today that a million "excluded Americans" suffer from inadequate health care.

These excluded Americans are migrant farm workers and their families. They have, for example, an influenza and pneumonia mortality rate twice as high as the national average.

Senator Williams pointed out that migrants live and work in rural communities where there are only half the medical personnel and services found in an average community.

These findings were detailed in a report on health care for migrant farm workers, made public today by Senator Williams, Chairman of the Senate Subcommittee on Migratory Labor.

The report, prepared for the Subcommittee by U. S. Surgeon General William H. Stewart, verifies a "health gap" among migrants previously suspected but never before delineated.

The extent of this gap has become clear with this report. Senator Williams pointed out, for example, that national per caplta health expenditures are almost 20 times greater than the per capita health expenditure for migrants. Six out of 10 of the counties serving as "home base" for migrant workers offer no personal health care to the farm workers,

While the average person visits a doctor four times a year, the migrant averages less than one visit a year.

In releasing the report, Senator Williams said:
"This legacy of neglect has taken a terrible toll of the migrant worker. Among the one million men, women, and children who travel the migrant stream, there are estimates of more than 5,000 with tuberculosis whose disease is undetected and untreated. There are more than 16,000 expectant mothers who will find it difficult or impossible to obtain pre-natal care."

Senator Williams, who recently introduced legislation to extend and expand the Migrant Health Program, pointed out that some progress has been made in health care for migrant workers.
"The program is well started," he said. "For the first time in a long history of neglect, the Migrant Health Program provides a mechanism to place this group higher on the health care priority lists of states and communities."

Migrant workers, who make up the seasonal labor base for more than 700 of the nation's 3100 counties, have received health services under Public Health Service grants to 112 public or private nonprofit community organizations. To date, $\$ 14.9$ million in health care and services have been provided under the Migrant Health Act of 1962.

Senator Williams anticipated the findings of the report when he reviewed the Migrant Health Program from the Senate floor two weeks ago.

He said: ""We have made some progress...but we have a long way to go. It is still the exception, rather than the rule, for the migrant farmworker and his family to have available even the barest minimum of medical service. We are operating this year with $\$ 7.2$ million. We could use almost double that amount of money simply to do a more effective job in the existing projects. In addition, we have many applications for new projects which the Public Health Service has been forced to turn down because of lack of funds."

## INTERIM REPORT ON THE STATUS OF PROGRAM ACTIVITIES UNDER THE MIGRANT HEALTH ACT (PUBLIC LAW 87-692)

A REPORT<br>TO THE<br>SUBCOMMITTEE ON MIGRATORY LABOR<br>of the<br>COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

SUBMITTED BY THE
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE Public Health Service JUNE 30,1964


Printed for the use of the Committee on Labor and Public Welfare
U.S. GOVERNMENT PRINTING OFFICE

COMMITTEE ON LABOR AND PUBLIC WELFARE LISTER HILL, Alabama, Chairman


## FOREWORD

Congress passed the Migrant Health Act of 1962 in order to provide better care to some of the Nation's neediest citizens-migratory farmworkers and their families. Not only proverty and ignorance, but also the migrant's necessarily transient relationship to the community had created tremendous obstacles to the meeting of these families' health needs. To help them, and to provide protection for others who might be endangered by occasional epidemics touched off by migrants illnesses, the 1962 act authorized grants for varied projects, with special emphasis on health service clinics.
This report, prepared by the Public Health Service at my request, reviews the first full year of operation under the act, and it gives a useful summary of what can be done when Federal, State, and voluntary groups work together to overcome one of the problems bred and sustained by poverty.
In my judgment, this first year's work has yielded impressive results and establishes a solid foundation for continuation and expansion of the program beyond its present expiration date of June 30, 1965. With the assistance provided under the act, State and local organizations have been enabled to provide several thousand migrant families with services such as these
Family health clinics, held at times and places where the migrants can reach them, for the treatment and prevention of illness.
Sanitation services, to aid in the correction of unsafe conditions such as contaminated water supplies and inadequate waste disposal.
Perhaps most important of all, health education, leading to active efforts by migratory families themselves to obtain proper care and maintain sanitary surroundings. The successes reported in health education are particularly timely in view of this year's enactment of two new programs-the President's antipoverty legislation and the Housing Act of 1964 -providing assistance for construction of new migrant farm labor housing.
At present, 55 health projects in 27 States are receiving grant assistance under the Migrant Health Act. The grants themselves have been modest: over half are for less than $\$ 20,000$, with an average of 40 percent of project costs contributed from other sources.
With the funds available so far, however, project coverage has been rather sparse. Of almost a thousand counties in the Nation using substantial amounts of migratory labor, the Public Health Service estimates that project services have reached only 17 percent. Even among those counties where migrants are most heavily concentrated those with 3,000 workers or more at the season's peak-over two-thirds are still untouched. In view of the valuable accomplishments already made by existing projects, I strongly hope that the Congress will approve a substantial expansion of the Migrant Health Act next year.

Harrison A. Williams, Jr.,
Chairman.

# INTERIM REPORT ON THE STATUS OF PROGRAM ACTIVITIES UNDER THE MIGRANT HEALTH ACT, JUNE 1964 

## Background

In the United States today, about 2 million American citizens, including dependents, are involved in the self-perpetuating conditions of illiteracy, insecurity, and poverty which dominate the life of the domestic migrant farmworker. The migratory work force is composed chiefly of southern Negroes, Americans of Mexican descent, American Indians, and Puerto Ricans.

Domestic migrants move one or more times each year in search of work along three major migration routes-from Florida along the east coast to New England, from Texas to the Rocky Mountain and Central States, and from California north into the Pacific Northwest. They may be away from the place they call home for periods of a few weeks to most of the year.

Their wage rates are low compared with those in industry, and their periods of work are interrupted by travel between jobs and periods when no work is available. Thus, their annual earnings average less than $\$ 1,000$ per worker.

Although the number of family farms and self-employed farmworkers has declined in recent years, the number of large farms-the chief employers of hired farm labor-has increased. Domestic migrants included one-fifth of the Nation's total seasonal hired farm labor force at the 1963 peak. They continue to perform a vital role in modern agriculture for a third of our Nation's counties.

In the past, reports of migrants' health status and services have shown-

Repeated serious outbreaks of diarrhea among their children.
Lack of early prenatal care and sometimes none at all for migrant mothers.
Diphtheria epidemics resulting from failure of community immunization programs to reach them.

Numerous unpaid medical and hospital bills for emergency care, some of which simple precautions could have reduced or prevented.
As the 1961 report of the Senate Subcommittee on Migratory Labor pointed out: "The constant interstate movement of migratory farm families prevents them from utilizing public health services generally available to other citizens. Their needs for health services are far from being met even though the conditions under which they live and work are
such that their need for health services is greater than normal * * *
Much of their disease and disability stems from poverty, filth, and ignorance, afflictions which migrants share with other impoverished people who -
TO Live in poor, overcrowded housing in a substandard setting.
Lack facilities for washing, bathing, and laundry - sometimes even water for family use.

Have little knowledge of good dietary and food handling practices, and no proper place for food storage.

Lack understanding of health needs, or proper health maintenance practices.

Lack funds to pay for care, even if need and suitable ways to cope with it are understood.
An added handicap for migrants in maintaining health is their employment far from urban centers where health resources are concentrated.

Some of the rural counties where they are employed lack health resources even for permanent residents.
Others, although well supplied, have health resources so concentrated at a distance from the places where migrants live and work that the travel involved to reach them is as great as the distance across some of the smaller States.
At best, few of their temporary work communities find it possible to expand and adapt their health resources to a large influx of needy newcomers who will soon move on. The community services migrants receive are not planned with their needs in mind, and are not coordinated with the services they may receive elsewhere.
Perhaps greatest of all their handicaps is migrants' frequent need to move in search of farmwork.

They seldom stay in one place long enough to learn the location of physicians or hospitals, the schedules of community clinics, the types of services offered by different local agencies, or proper ways to gain access to services that might be available to them.
Their movement disqualifies them for many types of aid afforded needy local residents. Because they move so often, they are "residents of nowhere."

As strangers wherever they go, they are often viewed with suspicion or outright hostility by local community residents. This magnifies their own fear of the community and makes them even more reluctant to request help for which they might qualify.


Each spring the migrants move northward, returning in the fall to Florida, Texas, and the Southwest when no work can be found elsewhere.
Source: U.S. Department of Labor, Bureau of Employment Security, 1961.

## The Migrant Health Act

The passage of the Migrant Health Act (Public Law 87-692) introduced by Senator Harrison Williams, chairman of the Senate Subcommittee on Migratory Labor, represented a major legislative breakthrough. Signed into law in September 1962, the act provides for financial and technical aid to those public or private nonprofit agencies which develop plans to extend community health services to migrant farmworkers and their families. Specifically, the law provides:

Grants by the Public Health Service to pay part of the cost of (1) family health service clinics;
(2) other types of projects to improve migrants' health conditions or services.
Expanded effort by the Public Health Service to improve migrants' health conditions or services.
In administering the law, the Public Health Service encourages the development of community projects which provide migrants personal health care in a setting that enables them to take increasing responsibility for meeting their own health needs. Such a setting requires-

Temporary expansion of local services as needed.
Scheduling of services at convenient times, and at places where migrants can reach them easily.
Arranging for necessary transportation for migrants who would otherwise have none available.
Recognizing migrants' low-income status resulting from their limited year-round earning opportunities.
Planning to overcome migrants' fear, suspicion, lack of facility in the use of English, lack of understanding of health needs and requirements to maintain good health, and other barriers to the effective use of community health services and the improvement of personal health practices.
The 1962 law authorizes a 3-year program ending on June 30, 1965. The congressional report indicates that "the purpose of the $3-y$ ear limitation is to compel an early review of the adequacy of the program * * *."

The following guidelines are considered in reviewing migrant health project grant applications:

Substantive merit and potential contribution of the project towards improvement of domestic agricultural migrant workers' health services and conditions.
Estimated number of migrants in the project area, and duration of local crop season.
Evidence of unmet health needs of migrants in the area.
Comprehensiveness of service, with emphasis on service to treat illness and disability and to prevent it to the extent possible.
Degree to which the project plan is adapted to migrants' circumstances and background.

Extent of planned coordination within the project area, and with other home-base and work areas in the same migrant stream.

Evidence of participation and commitment of resources by appropriate community groups: growers, migrants, physicians, nurses, hospitals, public and voluntary agencies, church groups, and others.

Adequacy of personnel, facilities, and other resources of applicant to carry out project.
Extent to which persons working with the project will be oriented to unique factors in migrant situation.
Proportion of cost assumed by the applicant organization or arranged by the applicant from other State or local sources (not only cash but also contributions of volunteered services, equipment, facilities, etc.).
Evidence that project will continue beyond the period of grant support.
Evidence that project may yield results, or may provide training opportunities, which will be useful to other interested persons and groups.

## Project Costs, Coverage, and Sponsorship

Requests for project grant assistance have consistently exceeded available funds. An annual appropriation of up to $\$ 3$ million was authorized for each of the program's 3 fiscal years. Of this amount-

In fiscal year 1963, $\$ 750,000$ was appropriated in midMay, solely for grants. The entire amount was immediately allocated to approved projects. Grants to assist other approved projects had to be delayed until the start of the next fiscal year on July 1.
In fiscal year 1964, $\$ 2$ million was appropriated. Of this amount, $\$ 1,500,000$ was for grants and $\$ 500,000$ for direct operations by the Public Health Service to improve migrants' health conditions or services. A backlog of approved applications will be carried over unfunded to the next fiscal year, starting on July 1.
For fiscal year 1965, the request of the Public Health Service for the full $\$ 3$ million authorized is now before Congress. Of this amount, $\$ 2,500,000$ will be for grants, and $\$ 500,000$ for direct operations will be continued.
New applications are constantly being received, as well as requests for continued support of projects previously granted assistance.


Forty percent of the total budgeted costs of grant-assisted migrant health projects have been met from other than Public Health Service grant sources.


EXAMPLES OF CONTRIBUTIONS FROM OTHER SOURCES --
hysicians' services
Dental care
Nursing services
Publicity and explanation of project to community groups
Laboratory services
Administrative services
(Receptionist, clerical, and janitorial services)
Professional consultation from
State health department staff
Services of interpreter for spanish-speaking migrants

Donated space for clinics Donated equipment or supplies Donated equipment or suppli Health education literature
$\qquad$ and films
Costs of hospital care for cases referred by project physicians
Other volunteered services or materials
or
Cash

Counties with the greatest number of migrants have the highest percentage of coverage by grant-assisted project services (March 31, 1964).
Covered by grant-assisted project servicesWithout grant-assisted project services

Public agencies have taken leadership in migrant health project development. Voluntary groups have filled the gap when others were not ready. They have also helped to interest other agencies in applying.


Regardless of formal sponsorship, most projects have broad community support. The following groups and interests are among those involved:

## Private individuals:

Physicians
Dentists
Nurses
Nursing students
Clerks and stenographers
Migrant workers who assist
. 15 in cleaning clinic quarters, "babysit" with children so mothers can attend clinic, etc.
Growers
Growers' wives
Pharmacists
Local newspaper and radio
Public agencies:
Public agencies-Continued
Employment service Surplus food distribution centers
Voluntary organizations:
Church groups
Medical societies
Farm bureaus
Red Cross
Parent-teacher associations
Growers' associations
Kiwanis clubs
Lions clubs
Visiting nurse associations
Travelers Aid
Travelers Aid
Tuberculosis and health asso-
Health departments
Welfare departments :omsteiz Salvation Army Tlofion vd
Schools
County hospitals
Colleges and universities
City and county law enforce
ment agencies
Girl Scouts
Voluntary summer schools and day care centers for migrant children Shrine Hospital

The majority of project grants are for less than $\$ 20,000$.
Amount of grant


Grantees budgeted the project grant dollar chiefly for health services.


Most projects provide a combination of family clinic, nursing, health education, and sanitation services. The following indicates the types of services offered separately or in combination with others by projects receiving grant assistance:

Family health service clinics at one or more locations in the project area, usually scheduled at night.
Nursing services in the migrant labor camps, in family clinics, and in day-care centers and summer schools for migrant children.
Sanitation services including camp inspections, work with camp owners and occupants to get improvements made in
facilities and their maintenance, and inspections of water supplies and toilets provided in the fields.
Health counseling of migrants by physicians, nurses, sanitarians, professional bealth educators, and subprofessional aides; public information and education to encourage community acceptance and cooperation.
Dental examinations and treatment.
Nutrition demonstrations and counseling to improve dietary practices.
Social work services to improve the outcome of referrals from family clinics or from nurses, and to help migrants meet the many problems interrelated with health.
Specialized clinics to provide immunizations, prenatal or postnatal care, and casefinding for tuberculosis, venereal disease, and vision or hearing defects.
Services of State consultants to assist county agencies and local communities in determining needs, developing project plans, and meeting problems of project operation.
Family health service clinics usually are scheduled at night, one or more times each week. Some are held in township halls, school buildings, church basements, labor camp housing units, or other improvised space.
Patients include men, women, and children. Treatment of illness or injury, immunizations and other preventive services, and simple medications are usually provided. A complicated case must generally be referred to a local physician's office or a hospital.
About half of the patients who received medical or nursing care during the first year were children under 16 and adults past 50 .
Among children, the conditions most often seen included-
Colds, other respiratory infections, and ear infections.
Measles, whooping cough, and other communicable diseases.

Impetigo and other skin conditions.
Parasitic infestations such as hookworm and round worm.
Diarrheal disease.
Other conditions-nutritional problems, accidental injuries and poisonings, head lice, ringworm, etc.


Among adults, conditions frequently reported were-
Upper respiratory infections ranging from colds to pneumonia.
Tooth decay.
Muscular aches and pains, "back troubles," arthritis, etc.
Gastroenteritis, "stomach upsets," etc.
Pregnancy.
Cardiovascular conditions.
Genitourinary infections.
Other conditions-accidental injuries, venereal disease, nutritional problems, defective vision or hearing, tuberculosis, etc.
Although grant funds cannot be used to pay for hospital care, some projects provided hospitalization with State or local financing. Many cases were emergencies. They included the following conditions

Pregnancy and its complications.
Accidental injuries including injuries resulting from violence.

Tuberculosis.
Pneumonia and other upper respiratory infections.
Diarrhea and dehydration.
Appendectomy.
Malnutrition.
Specialized clinics are held by some projects to provide immunizations, dental care, casefinding for tuberculosis and venereal disease, vision and hearing tests, and other special services.


Project nurses visit families to advise them on health matters, provide first aid, and encourage sick or injured persons to go to the family clinic or to a local physician. Nurses also work in the night clinics, supervise the health of migrant children in day-care centers and summer schools, and carry out numerous other activities.


Project sanitarians assist both occupants and owners of camps to improve the environment and thus reduce risks of needless disease and disability. In some cases the camp owner accompanies the sanitarian on his inspection tour. Together they identify defects and work out a plan for their correction.

The sanitarians also teach migrant families how to mend screens and make other simple repairs, and how to maintain housing units and grounds in a way that will protect their health and safety.

Simple cleanup, fixup measures help greatly to improve some camp situations.

Water supplies subject to contamination and poor methods of waste disposal are among the defects commonly found in migrant camps. Other common defects include-
inadequate toilets.
lack of screens, or screens in poor condition.
buildings in poor repair.




## safety hazards.

insufficient windows and doors.
overcrowding.
lack of bathing, laundry, refrigeration, cooking, lighting, or other equipment for family living.
location close to animal pens, refuse, dumps, or other hazards to health and safety.


Health workers, camp owners, and migrants work together in some project areas to improve the camp environment for family living.
Health education improved the acceptance of health services by many migrant families. The friendly advice given by physicians, nurses, and sanitarians whenever they contacted a migrant was one important form of health education. Some projects also employed health educators and aides to broaden and intensify their educational effort.

Health educators assisted other staff members in improving the effectiveness of their counseling. They also assisted in group educational sessions for migrants, prepared and tested leaflets and other educational materials, helped identify and interpret migrants' needs to health workers, and explained health workers' instructions to migrant families.

In addition, health educators often helped to gain community understanding and support of the project.


Nurse advises mother about infant care.

## Evaluation

A single crop season is too short to measure the effects of health education. Nevertheless, some projects made progress. The following reports are representative:
"Through the effort of the nurse, *** the migrants assumed personal responsibility for getting to ${ }^{*} * *$ clinics ${ }^{*} * *$ and all pregnant women were seen by private physicians * * *."
"After much preparation and guidance to the migrants, the enthusiastic response to the family service clinics and the other health services seemed to indicate acceptance of their worth * * *."
"By the end of the crop season the increased interest * * * in dental care was shown by the fact that one project had more requests for service than available time would allow
for appointments. Some migrants asked the project workers - to recommend area dentists for continued remedial work grl when they were notified of the limited time available through bo the project program."

One crew was observed at its next location after it left the project area. The crew members showed generally improved health conditions. Vitamins were still being taken as directed. The crew members had found discarded building materials and spent their first days in repairing doors, windows, and screens. Care was used in preparing baby foods and formulas. Mothers expressed gratitude over the fact that the new location provided a safe supply of drinking water.

A sanitarian reported: "A surprising number did remember what I taught them. * * * Some claimed most of the people in a given camp try desperately to keep things clean but that only a few are the culprits. This I found to be true." Specific health benefits resulting from projects included:

The discovery and treatment of several thousand persons requiring medical care who might otherwise have continued without attention, at least until their conditions became emergencies. One community reported a reduction of 75 percent in the hospitalization of migrants, and no deaths for the first time in at least 3 years.
The immunization of several thousand children and adults, some of whom had never before received immunization of any kind.
Dental examination and treatment, especially of children.
An increase in the number of migrants carrying a health record, so that treatment can be continued without duplicated effort in diagnosis and identification of effective therapy.

Improvements in the camp environment of thousands of workers and their families. One project, for example, reported that 75 percent of the camps in the area met local regulations at the end of the season compared with 5 percent at the beginning. Few projects made this outstanding a record, but many made a substantial start.

A sta,'t toward identifying the counties of origin and the destination counties of migrants, as a step toward linking the health services of one project area with those provided the same individuals elsewhere.
Other benefits were also attributed to project operation:

## Less violence in the migrant labor camps.

An opportunity for migrants to realize their own potentials through assisting in a community project; for example, a Puerto Rican migrant girl assisted nurses and physicians in
one project by volunteering as an interpreter for other Span-ish-speaking migrants. For her own career, she hopes to become a nurse. In another project area, two Negro teenagers assisted as aides in night clinics. One plans to become a social worker and the other, a nurse. The community is helping them realize their educational goals.
Improved community understanding and acceptance of migrants, public-voluntary cooperation, and working relationships between State and local health department staff members on behalf of migrants. In one area, the experience in public-voluntary cooperation in a migrant health project has led to exploration of ways to continue this cooperative effort on behalf of local needy people.

A clearer view of health efforts as part of a larger picture. Thus one project report observed: "These people have been dumped into an area by virtue of a mechanical cotton picker, which has left them without income, with squalid housing, without transportation, and lacking employment opportunities. Our job is *** to get these people back into a productive capacity ***. Health will be the entering wedge * * *. We believe that our interests * * * will be shared by a number of other agencies and by the ranchers ***. Our knowledge of these migrants indicates to us that the vast majority are ready to avail themselves of * * * opportunities, but cannot get over the hurdle of being stranded * * * with little employment and no means of transportation."
When grant funds first became available in 1963, migrants were already arriving in many project areas. An immediate start was urgent if people were to be served before they moved on. The pressure to get started complicated the already complex problems of a new project.

Delay in obtaining grant funds made recruitment of staff even more difficult. In some cases, key staff members could not be recruited, and the original project plan had to be modified.
Time was lacking for proper orientation of staff members to their jobs or to the migrant situation.

Recruitment and training of volunteers to perform key tasks was also difficult.
There was little time for working out effective relationships between paid staff and volunteers, among the different organizations with a potential contribution to make to the project and with interested individuals.
Available health education materials proved inadequate in the migrant situation.
Poor crop conditions in 1963 added to the problems encountered by some new projects.

Migrants were more than normally mobile as the result of drought, poor crops, and lack of local work opportunity in some project areas. There was even less than the usual
opportunity to work with a person or family over a period of time. Yet building rapport as a basis for acceptance of health services-as many project reports commented-takes time, especially with a group which has built up distrust based on past community rejection.

The fact that there was less than usual work opportunity also created problems related to health and health care For example, some fa:nilies lacked funds to purchase food, yet could not qualify for surplus food under the local mechanism for its distribution. This created additional problems for projects in teaching good nutrition practices.
In spite of their multiple problems, many projects also reported factors contributing to success in their first year:

Support and active cooperation of local physicians, dentists, hospital administrators; employment service; civic organizations; local migrant committees; and other groups.

Cooperative relationships with welfare workers in gaining access to needed social services, and successful working relationships with hospitals, leading to ready acceptance of migrants as patients.
Relatively small turnover in the local migrant labor force. (One large employer attributed the small turnover of his employees to the standards set by the organization. "First, we demand that they work, and, second, we demand that they live as human beings should * * *'")

Effective rapport with migrant mothers, teenagers, crew leaders, and other members of the migrant group who assisted in readying clinic quarters, cleaning up after each clinic session, and encouraging other migrants to use project services.

Assistance of health aides, in some cases drawn from among migrants or ex-migrants, in creating better understanding, and in identifying persons requiring health care and bringing them to the attention of project nurses.

The favorable attitude of some growers who looked upon project services as a "fringe benefit" for their workers and believed that keeping them in good health made them a better work force.

The involvement of community volunteers, which greatly enhanced community understanding and acceptance of migrants. Church groups, especially, stimulated interest in project development, recruited volunteers including professional health workers, and provided a link between migrants and the local community.
Suggestions for future program development were made by migrant health projects, based on their first year's experience:

STAFF AND STAFF TRAINING
Selection of staff on the basis of sincere interest and willingness to work toward bettering the migrant situation. The
director and other staff members should have a comprehensive view of the national migrant situation.

Early recruitment and preseason orientation of all personnel, including volunteers, to provide for clear understanding of duties and to whom to report regarding problems.

Involvement of personnel from the cultural group to be served, especially where language is a barrier to communication.

Carryover of staff from year to year to the extent possible, in order to minimize problems of establishing rapport.

## SPECIFIC SERVICE NEEDS

Recognition that migrants are most in need of the type of health care provided by general practitioners, plus dental care and provision for acute emergencies that cannot be delayed until the project nurse revisits a camp or until the next clinic session.

Greater availability of services beyond those that can be provided in a makeshift setting; e.g., hospital outpatient and other diagnostic and laboratory services; hospital carepossibly at the discretion of the project medical director.

Recognition of the need for transportation for many migrant patients.
Repeated visitation of camps to bring service to migrants' attention in recognition of the fact that they are in a strange rural area.

Exploration of welfare services as a possible adjunct to clinic services.

Legislation to establish and enforce housing and sanitation regulations where these do not exist; better definition of migrant and camp owner responsibility in the housing situation.
Project reports also emphasized other needs:

## IMPROVED COMMUNICATION

## With migrants

Recognition of migrants' need to have an opportunity to express their own health concerns.
Improvement of teaching methods and materials; increased emphasis on health education effort in prenatal care, infant and child care, nutrition, money management, and camp maintenance.

## With community groups

Much more interpretation of the need and the program to farmers, hospital administrators, and others whose cooperation is essential. Encouragement of growers to advise project staff about the migrants they will employ, when they will arrive, how long they will stay, their work schedules,
and other matters pertinent to the development of a sound health program.

Expanded use of community volunteers, establishment of local committees, and use of other measures to improve community understanding and attitudes toward migrants and toward the health project.
With other health or related activities in the same area and elsewhere
Improved coordination of effort within the project staff, and between the project and other community activities on behalf of migrants; early planning to work out relationships and schedules, and to define responsibilities held by different persons and groups.
More consistent use of personal health records carried by migrants, and recognition of those that migrants present; more definite solutions to the problems of interarea referral and means of providing health care for people on the move.

## IMPROVED PLANNING AND EVALUATION

Initiation of project planning and preparation well in advance of the crop season, and allowance of time for evaluation at the end.
Better evaluation measures for health education and other services.
Encouragement to employers to provide identification cards to migrants listing the names and birth dates of family members, and the name and address of the farmer who employs them
Recognition that health effort is part of a larger picture involving help to stranded people to make them part of the normal community.

## The Migrant Health Brance

To implement the grant program, the Public Health Service established the Migrant Health Branch. The staff includes consultants in medicine, nursing, sanitary engineering, health education, rural health, and public administration. The Migrant Health Branch has headquarters in Washington, D.C., and nine field representatives stationed in regional offices of the Department of Health, Education, and Welfare

The staff places major emphasis on-but its consultative role is not limited to-grant implementation. In connection with the project grant program, the Branch staff has-

Prepared program guidelines based on congressional intent; developed application and funding procedures.
Set up a cooperative reporting and evaluation procedure in which grant-assisted projects and the Public Health Service share in a joint effort to measure progress under the migrant health grant program.
Made information and consultation services available to interested persons and groups.

Cooperated with and utilized the experience of many groups including relevant Federal agencies, the Association of State and Territorial Health Officers, and an external project review committee composed of persons knowledgeable about migrants and about the fields of medicine, public health, agriculture, community organization, social science, and labor.
In addition to grant implementation, the Migrant Health Branch has responsibility for direct activities in connection with migrant health programs. These activities include:
(1) Assisting and encouraging interarea migrant health planning and program development in order to avoid duplication and gaps in services:

In cooperation with the Association of State and Territorial Health Officers, a key point has been designated in each State health department for contacts from within or from outside the State in relation to migrant health planning, referral of cases requiring followup care, and other related matters.
A personal health record designed to be carried by migrants has been made available. (The record was pretested by the Public Health Service in cooperation with Michigan and Texas. Thereafter, it was recommended by the Association of State and Territorial Health Officers for nationwide adoption.)
A conference was held of project directors and other key persons from East Coast States for the purpose of sharing experience and developing improved communication and coordination of effort. (Partly as an outcome of this conference, two major east coast areas which share the same migrant labor force at different seasons have developed a joint project plan. An interarea referral system presented at the conference will also be tested in several of the areas represented by conferees.) Similar conferences are planned in other areas of the United States.
The employment of a health education consultant, based in one regional office but working throughout a major stream of migration, is an experimental approach to better coordination of effort in the field of health education.
Each grant-assisted project has been encouraged to identify the source and the destination of migrants who live and work temporarily in the project area. This information can serve as a basis for future communication and joint planning among related home-base and work areas.
(2) Identifying problems that are difficult or costly for any single area to solve and setting up direct procedures for this purpose. For example:

The Migrant Health Branch is currently surveying the various methods and rates of compensating for medical, dental, hospital, and other health-related services for domestic agricultural migrant workers and their families. The survey will look into methods used by areas where grant-assisted projects exist and other areas.

Through a contract with a school of public health, an evaluation of health education materials currently in use with east coast migrants is underway. This will be the basis for a guide to be used in preparing, testing, and using health education materials and methods. A similar project is being negotiated in relation to materials for use with people from a Spanish-speaking background.

Three discussion-type health education movies have been prepared for use with migrants whose chief origin is in Southeastern United States. Negotiation is just starting for the development of similar movies for use with Spanish-speaking migrants.

Under a contract with the American Public Health Association, a national voluntary agency, the Branch is currently evaluating the migrant labor health program, its effectiveness in meeting migrant health needs, and the larger problems of health and health care in a rural setting, especially among low-income rural people.
(3) Carrying out a broad informational and consultative role, including:

Field visits, preparation and dissemination of informational materials, and participation in conferences and special orientation sessions.

Maintaining an information center on all aspects of migrant health, including such matters as techniques for working with migrants and for obtaining full use of available voluntary and public agency resources in migrant health program development. Information is drawn from grantassisted projects and from other public and private sources throughout the Nation.

Keeping in touch with a wide variety of interested individuals and groups, including organizations such as the following:

Voluntary
Association of State \& Territorial Health Officers.
American Public Health Association.
Rural Health Council, American Medical Association.
Migrant Ministry, National Council of Churches.
Bishop's Committee for Migrants.
Bishop's Council on the Spanish-Speaking.
National Council on Agricultural Life and Labor.
American Hospital Association.
National Consumers' League.
National Advisory Committee on Children and Youth.
American Farm Bureau Federation.
National Farmers Union.
National Tuberculosis Association.
Travelers Aid Association.
National Association of Social Workers.

National Education Association.
AFL-CIO
American League for Nursing.
American Nurses Association.
Society of Public Health Educators.
State Migrant Labor Committees.

Health departments.
Welfare agencies.
Departments of education.
Agricultural Extension Service.
Farmers Home Administration.
Farm Labor Service.
Bureau of Labor Standards.
Children's Bureau.
Federal Interdepartmental Committee on Children and Youth.
Vocational Rehabilitation Administration.
Office of Education
Housing and Home Finance Agency.
Research agencies of the Federal Government (e.g., National Institutes of Health).
Colleges and universities.
Other units of the Public Health Service (accident prevention, chronic disease, Communicable Disease Center, environmental health, nursing, health education, medical economics, etc.).

## Summary

The Chinese say, "The longest journey starts with but a single step." In summary, the first year under the Migrant Health Act has enabled many communities to take that essential first step. As a result:

The migrant is no longer as isolated from community services, nor is the community that tries to serve him as alone in its effort.

Time, place, and method of providing care have been adapted as communities looked at their health services through the migrant's eyes.
Public and private agencies have joined to make effective use of all available resources, including at times the help of volunteers from among migrants as well as from local groups.

The illnesses and injuries of many migrants have been treated, and their appreciation of modern medical care has been increased, as they received health services in a friendly project setting.
Migrant and community have reached better mutual understanding, and the gap between migrant and resident has been partially bridged.

Many problems remain and many areas still offer inadequate services or none at all to their migrant workers and families. Nevertheless, a start has been made.

Undergirding State and community efforts to know and work more effectively with migrant workers and families, the Public Health Service continues-
to identify and take steps to meet problems not easily solved by a single area working alone.
to assist in developing methods whereby services can be made more effective, and the services in different geographic areas related to each other, thus at some time in the future making continuity of health care, as it is needed, a realityeven for migrants.
to look at the experience gained, both within and outside project areas, so that the accumulated learning of all can be shared.

## APPENDIX A

## Public Law 87-692

87th Congress, S. 1130
September 25, 1962
AN ACT To amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes ( 76 Stat. 592 , 42 U.S.C. 242 h )

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, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families.
Approved September 25, 1962.

## APPENDIX B

## Migrant Health Proaects Assisted by Grants From the Public Health Service, August 1964

| State | Applicant |
| :---: | :---: |
| Arizona | Maricopa County Health Department. |
|  | Pima County Health Department. |
|  | Yuma County Health Department. |
| Arkansas | Northwest Arkansas Migrant Committee. |
| California | State department of public health. |
| Colorado | State department of public health. |
| Connecticu | State department of health. |
| Delaware | Delaware State Council of Churches. |
| Flori | Dade County Health Department. |
|  | Palm Beach County Health Department. |
|  | State board of health. |
| Indiana | Indiana State Board of Health (originally 2 projects-these were combined into 1 ). |
| Iow | Muscatine Migrant Council. |
| Kansas | Kansas State Board of Health. |
|  | Wyandotte County Health Department. |
| Louisian | Tangipahoa Migrant Committee. |
| Maryland | Frederick County Migrant Health Council. |
| Massachu | Health Research Committee. |
| Michigan | Michigan Department of Health. |
|  | Michigan State University (Agricultural Engineering Department). |
|  | Monroe County Health Department. |
|  | Ottawa County Health Department. |
| Minnesot | State department of health (division of environmental sanitation). |
|  | State department of health (divisions of disease prevention and control and of local health administration). |
| New Jers | State department of health. |
| New Mexi | Las Cruces Committee on Migrant Ministry. |
| New York | Genesee County Department of Health. |
|  | State department of health, Utica district office. |
|  | Suffolk County Department of Health. |
| North Caro | Carteret County Migrant Commission. |
|  | District Health Department, Elizabeth City. Henderson County Migrant Council. |
|  | State board of health. |
| Ohio | Darke County Health Department. |
|  | Lucas County Health Department. |
|  | Ohio Department of Health (dental health). |
|  | Ohio Department of Health (health education). |
|  | Ohio Department of Health (sanitary engineering). |
|  | Putnam County General Health District. |
|  | Sandusky County-Fremont City General Health District. |
|  | Stark County Health Department. |
| Oreg | State board of health. |
|  | University of Oregon (associated students). |
|  | Yamhill County Health Department. |
| Pennsylva | Pennsylvania Department of Health. |
| South Car | State board of health. |
| Texas. | Laredo-Webb County Health Department. |
|  | Lubbock City-County Health Department. |
|  | Plainview-Hale County Health District. |
|  | Southwestern Texas Health Department. |
|  | State department of health. |
| Virginia | Accomack-Northampton Health Department. |
| Washingt | Okanogan County Health Department. |
|  | Tacoma-Pierce County Health Department. |
|  | Catholic Diocese of Madison. |

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[^0]:    "(3) perhaps most important of all, health education, leading to active efforts by migratory families themselves to obtain proper care and maintain sanitary surroundings. The successes reported in health education are particularly timely in view of this year's enactment of two new programs. the President's antipoverty legislation and the Housing Act of 1964--providing assistance for construction of new migrant farm labor housing."

    At present, 55 health projects in 27 states are receiving grant assistance under the Migrant Health Act. With the appropriations made available so far, however, project services have reached less than 20 per cent of the Nation's counties using substantial amounts of migratory farm labor.

    Williams is Chairman of the Senate Subcommittee on Migratory Labor.

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