HEALTH PROBLEMS OF MIGRANT CHILDREN

Imagine, if you can, what it must be like to never know from one day to the next whether or not you will be on the move, or if your parents are working in the field, how long you will be staying in this particular camp or house. Imagine going from school to school, never knowing whether or not your friends will be there, what the attitude of the local children and teachers will be, whether or not you will be accepted or rejected. Think what it must be like to not understand the language, to have a teacher who doesn't understand you, and to not know the rules of the game because you have never been here before. If you have ever had a toothache, earache or stomach ache, think what it must be like to be denied help, medication, or comfort, and to have to wait until your parents come home from the fields before they could get you to some emergency room. In the meantime, there was nothing you could do but cry.

To some, the above may seem to be an exaggeration, or overreaction on my part. Regardless of what you think, I can assure you the above is true for thousands of migrant children. I know, because I have talked with them about these problems. I have had the experience of asking children, "where did you come from?" and their answer would be, "from the peaches," "from the cotton," never from a town or state, but always from the crop. I have asked, "where did you live before coming here?" and they have answered, "in the red house" or some other color of house, never from a city, county or state. I have asked parents, "when did your child last visit a doctor?" and I get the answer, "he has never been to a doctor", yet the child is in school! I have seen children with operative scars and the parents can't tell me what was done to the child, who did it and, in many instances, where it was done - just in Texas, or California, or some other place. I have had parents show me medicine that they were giving the child on a daily basis, yet they were not sure what was being treated.

I could go on and on with stories like this, but I think this is enough to give you an idea of the plight of the average Mexican American child who travels in the migrant stream. Theirs is, in many instances, a deplorable existance. Many are malnourished. Many have nutritional anemia.

The effects of this substandard existence manifests itself in many ways, not only in visible illness, but also in the class room. The psyche is frequently fractured and the child or the adult withdraws and loses the drive to "get ahead".

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In general, there is improvement in the availability of health care, not only for the migrant child, but also for the parents, but it is miniscule compared to what should be available. Although the government has poured billions into health care through Titles XIX and XX, the migrant child rarely benefits from these programs because he is not a resident of the state, or in many instances, his family has moved on before the paperwork is finished. The migrant family is eligible for health care (on a sliding fee scale) through the Migrant Health Clinics financed through the Bureau of Community Health Services. However, even here there are problems. In some instances, the hours of the clinic preclude evening and weekend visits. At other times, the clinic is so crowded that the migrant might lose a day's work, which he can't afford to do. The upstream migrant health clinic, or rural clinic, in order to exist during the winter non-migratory months, serves the local populace, which also must be served during the migratory months, and this leads to overcrowding and time delays. In many instances, the clinic is so far away from a particular crop or camp, that it's impossible for the families to avail themselves of the service. In these situations, the family must turn to the local practitioner, who may or may not serve them, or to the expensive hospital emergency room, which they can't afford, whom might demand payment in advance, which they don't have!

For the child enrolled in Title I Migrant Education, monies are available, to a limited extent, for emergency services, but all other sources of help must be exhausted before these monies can be spent, unless it is a true emergency and time is of the essence. In some states, through Title I, accident insurance is available for the migrant child, which is the same type of insurance that most school children have for athletics, etc., but at the present writing, only two or three states have this program.

The WIC Program of the Department of Agriculture has been a godsend to the migrant women, infant and child. This program, like the others, has its problems. The registration card is often lost and the parents spend hours or days being reidentified. Sometimes the program office, like the clinic, is located so far away from the camp or crop that it's impossible to obtain help because of the distances, so that it is again hours or days before help is available.

There are other factors which have an effect on the well-being of the migrant child. The failure of the Departments of Agriculture, Labor and Education to come to a common definition of the migrant, has placed restrictions on the consistent availability of help. The failure of many program people to

understand and accept the cultural differences of the Mexican American, or the truly Mexican family, and the failure of many of us to speak the language all have a bearing on the health, education, and welfare, not only of the child, but his family as well.

Dr. Joyce Brothers, in discussing stress as it relates to children, says "there are particular times in a child's life when moving from one school or one community to another creates a maximum of stress." Not just stress, but a maximum of stress! Along similar lines, Doctor Brothers notes that it's most important for a child to have a friend or chum in order to relieve stress. It's through such a relationship that children test themselves and gain self-knowledge and self-esteem. By talking things over with a friend and finding that they are not alone with their problems, they are able to relieve their anxieties and perceive their problems in a more favorable light.

The Mexican American family is closely knit and problems within the family are manifest in the child. Educators close to the scene know that a migrant child has difficulty in learning if there is trouble at home, and particularly if the mother is ill or demonstrates some unknown anxiety.

Although the diet of the migrant child is often minimal, there are some who suffer from nutritional deprivation, particularly is this true in infancy. The average migrant mother spends her days in the field and is unable to breast feed her child. The baby is often left in the care of an older sibling, or a young relative. The bottle is propped, there is no verbal or eye communication, which we are now learning is so important in the development of the personality. As the child gets older, it's easier to pacify him/her with a bottle of juice or some high carbohydrate drink. The child, whether drinking milk or some other liquid, frequently falls asleep with the nipple in his/her mouth. This leads to what is known as "nursing bottle syndrome" - severe tooth decay and loss of teeth at an early age. This decay usually affects the upper incisors first, then the molars and canine teeth and finally the lower incisors. Pregnant women will often forego food in order that the children be fed. If this results in severe malnutrition on the part of the mother, the resulting offspring will probably be underweight and will demonstrate retarded neuro-motor development.

It has been reported by numerous investigators that infants tested during and after rehabilitation of severe malnutrition show substantially reduced performance on developmental and cognitive tests. Although we all think this type of malnourishment is present only in the developing countries, it has been reported in many parts of our country. There is good

evidence that this reduced performance may persist for some period of years after rehabilitation from severe malnutrition.

The more severe the nutritional deprivation in early childhood, and the longer it continues without treatment, the greater is the likelihood of intellectual impairment. If this severe malnutrition occurs later in children, the outcome relative to intellectual impairment is more favorable.

Although we, in the United States, see few cases of severe malnutrition (infantile marasmus, kwashiorkor), we are becoming more aware of chronic undernutrition in low income families. In ethnic groups, nutritional inadequacies and nutritional deficiencies are more prevalent. Dietary intake of nutrients have been assessed in several studies and results indicate that many people have an inadequate diet because of poor food choices and/or inadequate money to purchase enough food. This was clearly shown in the Ten State Nutritional Survey done in 1968.

Chronically undernourished children often are less responsive and attentive; they are unable to sustain prolonged physical or mental effort. Some studies have shown that these children lag behind their well-nourished counterparts in intellectual development. An interesting finding in one study was that taller children made fewer errors in performing tasks used as a measurement of development than short children. The same was true of the ability to integrate information received from audio and visual stimuli. Associated with the above is, of course, the question of environmental deprivation and the intellect of the parent or parents.

Many migrant children suffer from iron deficiency anemia. It has been suggested that children suffering from chronic iron deficiency exhibit a decrease in attentiveness and purposeless activity, while there is an increase in irritability.

Another fairly common problem seen in migrant children is that of obesity. Obesity has been cited as the most widespread form of malnutrition in the United States. The relationship of disease to obesity has been well documented, but there is another facet of obesity that is equally crippling - namely, the emotional and psychological trauma associated with this disease. The overweight (obese) individual, especially the 5 to 17-year-old, is subject to social attitudes that tend to be uncomplimentary, contemptuous, and censorious These individuals experience varying degrees of wretchedness and self-disdain. These feelings influence the way the individual perceives himself and his world.

We cannot leave this discussion of undernutrition without saying a word about hunger and here we must rely on the observations of teachers and administrators who see the child who has had no breakfast, who skips lunch because of lack of funds, or lack of food in the home to prepare a lunch. Teachers and administrators frequently comment about the apathy, inability to pay attention, disruptive behavior patterns and overconcern about food seen in hungry children. It is reasonable to believe that such behavior has a deleterious effect upon his learning ability.

A study by Thorpe et al, "Developmental Assessment of Pre-school Children of Migrant Farm Worker Families in California", 1971-1975 from the Department of Applied Behavioral Sciences and Department of Community Health, School of Medicine, University of California, Davis drew the following conclusions:

> "Young migrant children in California, as in the other great migrant streams in the U.S.A., have a number of health problems that are apt to affect their development and school performance:
>
> 1. They have poor record of immunization and dental care.
> 2. The height and weight measurements of a sizable proportion of migrant children show the stunning effects of poor or marginal nutrition.
> 3. Their health histories and physical examinations reflect the synergistic interaction of marginal nutrition, diarrhea, chronic respiratory and parasitic infection as well as exposure to repeated accidents and injury.
> 4. Singly, and in combination with a higher than average incidence of vision and hearing problems, poor health and nutritional status have an accumulative affect on the children's development.
> 5. Together with frequent changes of residence which deprive them of health care and follow-up, and lack of exposure to the English language, these health problems are apt to lead to difficulties in school."

The results of a summer health program in the State of Washington in 1978 are illustrated in Charts 1 and 2. These findings were collaborated by the 1978-79 survey of 5,000 migrant children (Chart 4). The detailed statistical study of this group has not been completed, but will be reported at a later date along with 5,000 examinations to be completed in the 1978-79 year.

In the second year of the Washington State Study, there appeared to be a great deal of difference between the true migrant (inter state) and the settled out migrant. The original 5,000 examinations are now being analyzed and reports will be made on health as it related to the U.S. Office of Education definition of a migrant child.

A study by Duncan et al., published in the September 1979 issue of American Journal of Public Health entitled, "The Comparison of Growth; Spanish Surnamed and Non-Spanish Surnamed Children" was abstracted as follows:

> "Weight, height, and head circumference measurements of 4,167 Spanish surnamed school aged children were compared with similar data from 2,322 non-Spanish surnamed children who resided in the same Denver, Colorado neighborhoods. These data were also compared with data from six other studies.
>
> Both male and female Spanish surnamed children were found to weigh less, be shorter and have smaller head circumference than non-Spanish surnamed children living in the same Denver neighborhoods. The sizes of the children in these populations residing in lower and lower middle class neighborhoods were closer to each other than to the sizes of children from middle and upper middle socioeconomic classes as measured in previous studies or to the size of children in the recently published cross-sectional National Center for Health Statistics study. Such comparison suggests that gross retardation is more a reflection of socio-economic factors than of ethnic genetic factors."

The 1979 report of the Indiana Family Health Council, Inc. on the results of a "la programa de salubridad para nos ninos" is in keeping with the previously quoted studies. Abnormalities found were classified as "episodic" which included such things as upper respiratory infections, pediculosis, impetigo, parasitic infections and minor gastrointestinal upsets. The second classification was "major medical" which included diagnoses of heart murmur, undescended testis, otitis media, growth and developmental delays and low hemotocrits. One thousand two hundred and ten (1210) children were screened. Three hundred and thirty seven (337) (27.85%) had episodic problems. Two hundred forty three (243) (20.08%) had major medical problems. One thousand two hundred and ten (1210) were examined, five hundred and twenty seven (527) (43.55%) had medical problems.

A study of the deaths of migrant students as reported to Migrant Student Record Transfer System (MSRTS) are shown in Chart 3. These percentages far exceed those of similar age in the United States as reported by the Department of Health, Education and Welfare. As a result of these findings, Title I Migrant Programs were instructed to include swimming, firearm safety, driver education, and first aid in their curriculum. The extremely high incidence of accidental death was as reported, but there is a question as to how many of these were from farm related although not reported.

Mental health as related to the family as a whole, is reflected in the children. This is best understood by quoting from the "report of the panel on migrant and seasonal farm workers" submitted to the President's Commission on Mental Health, February 15, 1978.

> "Our study leads us to believe that while there are obvious merits to any efforts aimed on improving mental health services to the farm worker population, unless such efforts are accompanied by concurrent policies and programs aimed at relieving the economic plight of migrant and seasonal farm workers, such efforts will be tantamount to planning for failure. The panel shares the conviction of farm workers advocates and others familiar with their living and working conditions that economics play a significant causative role in the manifestation of mental health problems by farm workers and that any programmatic approach must take this causation into account.
>
> In our view, any efforts of remediating the mental health problems must be concerned not only with the symptoms, but with the root causes. For this reason, the panel firmly believes that the models of primary prevention mental health services and of social action treatment theory and practices are the models of choice. We assert that the farm worker population represents an especially vulnerable high risk group within the nation for whom preventative mental health strategies must be developed and implemented to reduce the social and economic stresses to which farm workers are subjected. It is our view that all federal programming to meet their needs should address itself to the objectives of integrating them fully into the community and encouraging their full participation in all programs and policies which affect their lives."

"Current federal categorical programs not only fragment services to farm workers, they separate them from the rural communities of which they should be a part. Migrants are further separated by their mobility as they travel from place to place in search of employment. They move from one community to another, a part of none, forever outsiders, isolated from the life of the community, living outside its boundaries in filthy labor camps, always moving as the crops ripen and the next harvest beckons. Nor are they able to establish a community within the migrant stream: each season they may travel with different companions dependent upon the vagaries of weather, crop failures, equipment breakdowns and other factors over which they have no control. Often, their families move with them, the children attending one school after another, or working the fields to help the family earn enough money to survive. Schooling at best, is a stop and start sporadic process, one from which many drop out, discouraged by what they perceive as their failure, thus decreasing their chances to alter their lives substantially. Their sense of self-worth and self-esteem suffers as a direct result; many come to feel that they are dispensible and of little value."

"IT IS THE PANEL'S VIEW THAT AN AGRICULTURAL SYSTEM WHICH PERMITS, EVEN UNINTENTIONALLY ENCOURAGES, THE SEPARATION OF THE FARM WORKERS FROM THE LIFE OF THE COMMUNITY IS A SYSTEM WHICH CAUSES MORE HUMAN MISERIES AND CAN NOT BE JUSTIFIED UNDER ANY CIRCUMSTANCE. THE BURDEN OF PROVIDING THE HUMAN SERVICES WHICH THE FARM WORKERS AND THEIR FAMILIES SO DESPERATELY NEED FALLS NOT UPON THE EMPLOYER OF THE FARM LABORER, BUT UPON THE TAXPAYER, WHO MUST ASSUME THE COST OF PROVIDING THESE SERVICES. IN NO OTHER INDUSTRY HAVE THE ECONOMIC RISKS BEEN SHIFTED SO DIRECTLY FROM MANAGEMENT TO THE PUBLIC, WHICH MUST COMPENSATE, THROUGH THE PROVISION OF HUMAN SERVICES, FOR THE ABUSES WHICH THE FARM WORKER ENDURES AS THE RESULT OF THE AGRICULTURAL INDUSTRY'S FAILURE TO ATTEND TO THE NEEDS OF ITS OWN WORK FORCE."

The highlights and recommendations of another report entitled "Health Needs of Migrant Workers in Wisconsin" from the Department of Rural Sociology, University of Wisconsin, 1978 are as follows:

"As a group the migrants are not fluent in English; their educational attainment is poor; their low family income places them in conditions of poverty; and they must travel thousands of miles each year in search of work. About one in four migrant workers comes alone, leaving friends and families in other parts of the country. The remainder come with their families and relatives and work as a unit. Most of the family groups work in the fields, whereas most of the "singles" work in canneries."

"About 90 percent of the migrant workers are of Mexican heritage. As a group, they perceive their health to be much poorer than other Americans. They list more bothersome health conditions and a larger proportion of the group is troubled by them. Numerous health problems prevail for the group as a whole including headaches, eye problems, nervousness, backaches and such chronic conditions as high blood pressure, diabetes and arthritis. Migrant women report histories of unusually high fetal loss and infant and child mortality. Women tend to report more bothersome health conditions than men but they have similar utilization patterns. Workers who speak only Spanish report their health as poor, report more health conditions that bother them and utilize fewer medical services than other migrant workers."

"Health status depends in part on the individual and his or her health habits. Access to health providers and continuity of care is much more difficult for migrants than for most Americans."

Recommendations:

1. Upgrade the level of preventative care.
2. Improve access to health services.
3. Encourage individual self-care.
4. Provide programs for improving mental health.
5. Coordinate efforts of outreach workers.
6. Enforce existing environmental regulations.
7. Involve migrants in health planning process.

In 1979 the Interstate Migrant Education Task Force of the Education Commission of the States published an intensive report on Migrant Health. The following is the Executive Summary of that report.

Executive Summary

One of the continuing concerns of the Education Commission of the States Interstate Migrant Education Project since its inception in 1976 has been the health of migrant workers and their families. Although the health of migrant children and their families has not been emphasized per se, due to the educational focus of the project, the task force has generally agreed that this is an area of vital concern, particularly as it relates to successful participation in education programs. As expressed in early task force deliberations, the rationale for addressing migrant health needs is that it is difficult to effectively educate migrant children if they are sick, hungry, poorly clothed or housed, or if any members of their families, particularly their parents, are ill. While this statement is applicable to the education of any child, it is particularly relevant for the migrant child because of the inherent life-style of the interstate migrant family. The life-style of the interstate migrant farm worker and his family is characterized by frequent moves, substandard housing, inadequate plumbing, and limited access to quality medical and dental services.

The task force has found that accurate information pertaining to migrant health is generally unavailable or buried in a myriad of agency files and reports. Much of the information is unsubstantiated. Nevertheless, several recurring themes appear in reports available on the health status of migrant workers. For example:

- The migrant's life expectancy is 49 years, compared to the national average of 73.

- The infant mortality rate among migrants is 25 percent higher than the national average.

- Birth injuries result in many cases of cerebral palsy and mental retardation.

- The migrant death rate from influenza and pneumonia is 20 percent higher than the national average, and deaths from tuberculosis and other communicable diseases are 25 times higher.

- The migrant's hospitalization rate from accidents is 50 percent higher than the national average.

- The migrant's two most chronic conditions are diabetes and hypertension, both of which require continuous care and followup.

- Poor nutrition causes pre- and post-natal deaths, anemia, extreme dental problems, and poor mental and physical developmental of the children.

- The largest outbreak of typhoid in recent history occured in a migrant camp in Dade County, Florida, in 1972 and was traced to a contaminated water supply.

Some of the major findings of the task force in the health area are:

- The health needs of migrants in all service areas, including preventive education, nutrition, dental, routine checkups, treatment and emergency medical care, are critical.

- There are many entities with specific mandates or that purport to serve migrant health needs. Yet, those needs continue to be unmet.

- Data, programs and related information suggesting provision of service to migrant children with special needs, such as handicapped children are largely unavailable.

- A large percentage of the health problems identified among migrant families is attributable to unsanitary and unsafe working conditions.

- At the federal level, the meager health care delivered to migrants is, for the most part, provided by services through the migrant health program, although prospects for improvement appear brighter.

- Migrants are routinely excluded in most states from services available through various entitlement programs contained in Titles XIX and XX through a tangle of residency and annual income eligibility requirements.

- Agricultural farmwork benefits as an industry in that the health care of its workers is paid by the federal government as opposed to the industry itself.

- There is no clearcut leadership for development of sound policy relating to migrant health in the United States.

- Many alternative approaches that warrant further study and support have been initiated at the state and local levels.

As a first step toward the resolution of the unmet health needs of migrant workers and on the basis of its findings, the Interstate Migrant Education Task Force maintains that:

> The migrant farmworker and his family are entitled to parity health, economic opportunity and educational access. Optimal health is important to educational achievement and overall development of all children and should, therefore, be equally emphasized for the migrant child. The task force urges that the following alternatives be considered for future action in the area of health services for migrant farmworkers and their children:

1. Appoint an oversight committee on migrant health. This committee would report annually on the status of migrant health to the U.S. House of Representatives Committee on Education and Labor.

2. Establish a national task force on migrant health to develop recommendations for the Secretary of the Department of Health, Education and Welfare.

3. Continue to evaluate migrant health clinics periodically and prepare recommendations for modifications in services, funding procedures and program administration.

4. Encourage counties and states to establish the health needs of migrant farmworkers, fishers and loggers as a priority service population, particularly as those needs can be served through Titles XIX and XX.

5. The MSRTS health records of migrant children who reside in non-Title I project areas be made available to private physicians and migrant health clinics to promote continuity of services.

6. Migrant children be specifically listed in existing and any new health legislation.

7. Place a new emphasis on prevention in migrant health and provide resources to develop capacity to extend health care and carry out initiatives in this area.

8. Initiate a study in the areas of exceptional migrant children, including gifted, handicapped, abused and neglected, to determine what the needs are in these areas and to find out whether these needs are being met by federal, state and local programs.

9. Determine avenues whereby the agricultural and fishing industries can take a more active role in the health and welfare of migrant workers and their families.

10. Identify methods whereby national health organizations, such as the American Academy of Pediatrics and the American Medical Association, can, in conjunction with federal,state and local programs, e.g., USOE Title I Migrant, Head Start, Comprehensive Employment and Training Act, Farmers Home Administration, and Titles XIX and XX, foster joint planning for coordination purposes and thereby assist in resolving migrant health needs.

The health and education problems of the migrant child are not insurmountable. The problems lies not so much with the family of the child as does with the bureaucracy surrounding this sequence of our society. If there were cooperation between all agencies, federal, regional, state, county and local educational associations, many of the roadblocks would disappear. The migrant families, as a whole, want the best for their children just like all the rest of the families do in this country of ours.

The problem can and will be solved, but not before prejudices are resolved and barriers overcome.

Chart I

Health Problems and Referrals by Age Groupings

	Number of Patients	Health Problems Identified	Referrals
Infants	31	20 (64.52%)	1
1 - 4	270	204 (75.5%)	23
5 - 8	310	118 (38.1%)	10
9 - 13	197	100 (50.7%)	7
No Date of Birth Given	11	5 (45.4%)	/
Total	825	447 (54.2%)	41

5 percent of the total were referred or 9.2 percent of the Identified Problems.

Chart II

Health Problems and Referrals by Health Condition

	Infant	1-4	5-8	9-13	No Date Given	Total
Anemia	1	29	35	48	2	115
Upper Respiratory Infec.	3	48	7	2	1	61
Otitis Media & Other ear disorders	3	40	9	6	1	60
Dental Caries (severe)		5	17	17		39
Skin Diseases	4	20	8	2		34
Heart Murmur	1	9	11	2		23
Eye Diseases	3	9	4	3		18
Large Tonsils		4	6	5		15
Abrasions, Lacerations, and Scarring	2	7	3	3		15
Nutritional Disorder		2	5	6		13
Orthopedic Problems		6	3			9
Undescended Testis		7				7
Developmental Delay	1	3		2		6
Hernia	1	1	1	1	1	5
Speech Disorder		1	1	1		3
Parasitic Infection		2	1			3
Congenital Heart Disease		1	1	1		3
Learning Disorder		2				2
Thrush		2				2
Headaches			1			1
Abdominal Mass		1				1
Asthma		1				1
Lung Disorder		1				1
Early Closure of Sutures	1					1
Anal Fissure			1			1
Seizure Disorder		1				1
Urinary Tract Infection		1				1
Hypertension			1			1
Personality Disorder			1			1
Erbs Paralysis				1		1
Telangiectasia			1			1
Splenomegaly		1				1
Enuresis			1			1
TOTALS	20	204	118	100	5	447

Chart III

MIGRANT STUDENT DEATHS AS REPORTED TO MSRTS

Cause of Death	Age-0 to 5	Age-6 to 10	Age-11 to 15	Age-16+	Total
	17	53	77	56	203
Car Accident	8	29	29	24	90 (44.3%)
Drowning	2	14	26	8	50 (24.6%)
Gunshot	1	3	5	12	21 (10.3%)
Burns	-	4	4	3	11 (5.4%)
Farm Accident	1	2	4		7 (3.4%)
Electrocution	-	-	3	1	4 (1.97%)
Suffocation	1	-	2	-	3 (1.4%)
Accident Unclassified	-	1	-	2	3 (1.4%)
Fall	2	-	-	-	2 (0.98%)
Carbon Monoxide	-	-	-	2	2 (0.98%)
Hanging	1	-	-	-	1 (0.5%)
Unreported	1	-	-	-	1 (0.5%)
Boating	-	-	1	-	1 (0.5%)
Fall from Truck	-	-	1	-	1 (0.5%)
Choked	-	-	1	-	1 (0.5%)
Strangled	-	-	1	-	1 (0.5%)
Stabbed	-	-	-	1	1 (0.5%)
Suicide	-	-	-	1	1 (0.5%)
Sniffing Anti-Fungal R_x	-	-	-	1	1 (0.5%)
Murdered	-	-	-	1	1 (0.5%)

CHART IV

2,042 (71.22%) PROBLEMS ENCOUNTERED IN
2,867 SCREENINGS

#	RANK	DIAGNOSIS	#CASES	PERCENT
1.	1	Dental caries	555	27.17
2.	2	Anemia	287	14.05
3.	3	Failed vision screen	137	6.70
4.	4	Abnormal heart sounds	120	5.87
5.	5	Otitis media	116	5.68
6.	6	Enlarged tonsils	102	5.19
7.	7	+ TBC test	90	4.40
8.	8	Contagious diseases (lice, chicken pox, scabies)	76	3.72
9.	9	Obesity	59	2.88
10.	10	Urinary tract infection	56	2.48
11.	11	Vision to be retested	48	2.35
12.	12	Hearing to be retested	36	1.76
13.	13	Abdominal pain (appendicitis)	25	1.22
14.	14	Abnormal urinalysis	19	0.93
15.	14	Phimosis	19	0.93
16.	15	Lymphadenopathy	17	0.83
17.	16	Rhinitis	12	0.58
18.	16	Pharyngitis	12	0.58
19.	16	Malocclusion	12	0.58
20.	16	Scoliosis	15	0.73
21.	16	Undescended testicle	12	0.58
22.	17	Hearing loss requiring referral	11	0.53
23.	17	Tympanosclerosis	11	0.53
24.	18	Uvula abnormality	10	0.48
25.	18	Dental referral for cleaning	10	0.48
26.	18	Contact dermatitis	10	0.48
27.	18	Possible hypertension	10	0.48
28.	19	Dermatitis N.O.S.	9	0.44
29.	19	Small for age	9	0.44
30.	20	Strabismus	8	0.39
31.	20	Otitis Externa	8	0.39
32.	21	Cardiac arrhythmia	7	0.34
33.	21	Abnormal menstruation	7	0.34
34.	22	Pyodermia	6	0.29
35.	22	Eczema	6	0.29
36.	23	Conjunctivitis	5	0.24
37.	23	Gingivitis	5	0.24
38.	23	Fungal dermatitis	5	0.24
39.	23	Ichthyosis	5	0.24
40.	23	Pulmonary abnormalities (rales-asthma)	5	0.24
41.	24	Muscle imbalance (eye)	4	0.19
42.	24	Speech disorder	4	0.19
43.	24	Keloids	4	0.19
44.	24	Seborrhea	4	0.19
45.	25	Seasonal allergy refer for testing	3	0.14
46.	25	Perianal rash	3	0.14
47.	25	Acne (severe)	3	0.14
48.	25	Poor hygiene	3	0.14
49.	25	Injury (ankle, forearm, finger)	3	0.14

PROBLEMS ENCOUNTERED IN SCREENINGS
(CONT.)

#	RANK	DIAGNOSIS	#CASES	PERCENT
50.	26	Amblyopia	2	0.09
51.	26	Cholesteotoma, ear	2	0.09
52.	26	Lesion palate	2	0.09
53.	26	Broken teeth	2	0.09
54.	26	Monilia diaper rash	2	0.09
55.	26	Boil	2	0.09
56.	26	Herpes simplex	2	0.09
57.	26	Ecchymosis (injury and disciplinary)	2	0.09
58.	26	Vitiligo	2	0.09
59.	26	Warts	2	0.09
60.	26	Diarrhea	2	0.09
61.	26	Hernia	2	0.09
62.	27	Seizure disorders	1	0.05
63.	27	Facial tic	1	0.05
64.	27	Headaches	1	0.05
65.	27	Pterygium	1	0.05
66.	27	Burn conjunctiva	1	0.05
67.	27	Unequal pupil size and light reaction	1	0.05
68.	27	Chronic otitis with hearing loss	1	0.05
69.	27	Absence of ear canal	1	0.05
70.	27	Repaired cleft palate with speech defect	1	0.05
71.	27	Deviated nasal septum	1	0.05
72.	27	Enlarged thyroid	1	0.05
73.	27	Petechiae palate	1	0.05
74.	27	Cleft palate	1	0.05
75.	27	Mouth scarred from burn	1	0.05
76.	27	Abscess tooth	1	0.05
77.	27	Gynecomastia	1	0.05
78.	27	Pityriasis alba	1	0.05
79.	27	Petechiae from injury	1	0.05
80.	27	Bee sting local reaction	1	0.05
81.	27	Perianal skin tag	1	0.05
82.	27	Pharyngeal mass	1	0.05
83.	27	Hyperpigmentation	1	0.05
84.	27	Filiform mole	1	0.05
85.	27	Abnormal kidney function	1	0.05
86.	27	Splenomegaly	1	0.05
87.	27	Bow legs	1	0.05
88.	27	Decrease function elbow (injury)	1	0.05
89.	27	Back pain	1	0.05
90.	27	Short leg	1	0.05
91.	27	Flat feet	1	0.05
92.	27	Myalgia	1	0.05
93.	27	Abnormal sternum	1	0.05
94.	27	Neuromuscular abnormality	1	0.05